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

PRINTED: 12/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185364	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENTON MANOR CARE AND REHABILITATION CENTER	905 HWY 127 NORTH OWENTON, KY 40359

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F 000	INITIAL COMMENTS An abbreviated survey was initiated on 12/05/12 and concluded on 12/06/12 to investigate KY19479 and KY19465. The Division of Health Care found KY19465 to be substantiated with regulatory violations. A statement of deficiencies was issued. The Division of Health Care found KY19479 to be unsubstantiated with no regulatory violations.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owenton Manor Care and 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."	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the	F 203	1. Resident #1 was discharged from the center on 12/3/12 and is currently receiving care at an inpatient facility. The center will re-evaluate resident for possible readmission to the center when resident is ready for discharge from the inpatient facility. The responsible party was provided with the Transfer/Discharge notice on 12/5/12 by the Administrator.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Lisa A Romans	X Administrator	X 1-11-13

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

BJB

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F 203	Continued From page 1 facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy, it was determined the facility failed to notify the resident or resident's legal representative of a transfer and discharge for one (1) of six (6) sampled residents and four (4) unsampled residents. Resident #1 was transferred to a hospital two times in November and recently on 12/03/12. The facility failed to issue a transfer notice on 12/03/12 and made the decision not to accept the resident for readmission. No written notice of discharge was issued that included appeal rights until surveyor intervention.	F 203	2. The Social Services Director educated residents in attendance at the Resident Council meeting on 1/8/13 regarding the center policy on Transfer/Discharge notice. The Social Services Director educated responsible parties at the Family Council meeting on 1/8/13 regarding the center policy on Transfer/Discharge notice. The Administrator sent a letter to current resident's responsible parties on 12/28/12 to inform them of the center policy and responsibility regarding Transfer/Discharge notice. Residents who had encountered a transfer or discharge within the past 30 days were reviewed by the Director of Nursing on 1/9/13 to determine if notice of Transfer/Discharge had been provided. A copy of the Transfer/Discharge notice was provided to 5 residents/responsible parties that had not previously received on 1/9/13 by the Social Services Director.	

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F 203	Continued From page 2 The findings include: Review of the facility's policy titled, Transfer/Discharge & Bed-Hold Notices, effective date December 2009, revealed the facility would provide written information regarding this policy during the admission process and again at the time of transfer for hospitalization. If the facility determines that a transfer or discharge of a resident is required, the facility would abide by all applicable requirements, including provision of adequate notice to the resident/legal representative. The policy revealed a notice of discharge or transfer must be made by the facility at least 30 days before the resident is transferred or discharged, except for situations where the safety of individuals would be endangered. In that case, notice may be made as soon as practicable before the transfer or discharge. Interview with the Administrator, on 12/05/12 at 1:10 PM, revealed Resident #1 had been transferred to a hospital's psych unit for treatment on 12/03/12. The Administrator stated she had called the resident's daughter and informed her the resident could not return to the nursing facility. She indicated the nursing facility was not able to care for the resident. When asked what needs the facility could not meet, she replied she was afraid Resident #1 was going to hurt another resident. When asked if a transfer/discharge notice had been provided to the resident/responsible party, she replied, "No." The Social Worker was in the room during this interview and she revealed she had not issued a written discharge notice to the resident or daughter (who is Resident #1's responsible	F 203	3. As of 12/28/12, the Administrator, Director of Nursing, and Social Services Director were re-educated by the Manager of Clinical Operations regarding the policy on Transfer/Discharge notice. Licensed Nurses will be re-educated by the Administrator, Director of Nursing, and/or Assistant Director of Nursing regarding the policy on Transfer/ Discharge notice and the requirement to send written information with the resident or responsible party during a transfer/discharge by 1/19/13. An evaluation will be given after the education to validate staff understanding. When a transfer or discharge from the center is necessary the center will provide written information regarding the Transfer/Discharge policy. In addition, the center Administrator or Social Services Director will provide a follow up phone call to the transfer/discharge resident's responsible party to ensure written notices have been received and/or to review them and answer any questions if needed.	

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F 203	Continued From page 3 party). Review of Resident #1's closed clinical record revealed the facility admitted the resident on 06/01/12 with diagnoses of Alzheimer's Disease, Attention or Concentration Deficit, Frontal Lobe and Executive Function Deficit, Diabetes, Depressive Disorder, and history of Traumatic Brain Injury from a motor vehicle accident in 2007. The clinical record revealed the resident was transferred to a psych hospital for treatment on 09/05/12, 10/30/12, 11/27/12, and 12/03/12. The clinical record revealed no documented evidence a written notice of transfer or discharge was provided to the resident or responsible party for any of those dates. In addition, there was no documented evidence a written discharge notice was provided to the resident/responsible party prior to the 12/03/12 transfer to the hospital. Continued review of the clinical record revealed on 12/04/12 at 2:10 PM, the administrator had documented she called the daughter and informed her the facility was not planning on taking the resident back. Interview with Resident #1's daughter, on 12/05/12 at 5:45 PM, revealed she had just received a faxed copy of a notice of transfer/discharge about an hour ago. The daughter stated the facility had called on 12/03/12 and informed her that Resident #1 had been transferred to the hospital. In addition, she had received a call from the facility's administrator, who told the daughter the facility was not planning on taking the resident back. The daughter stated she would like the resident to stay at this facility because she did not know of any other facilities who would take the resident. The daughter	F 203	4. The Social Services Director began tracking each resident transfer and discharge as of 12/28/12 to determine that written information regarding Transfer/Discharge policy had been provided and that the follow up phone call had been completed. The Administrator/Social Services Director will discuss the results of this tracking monthly for three months and then at least quarterly at the Performance Improvement Committee meeting for further review and recommendations. 5. Completion date 1/20/13	

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F 203	Continued From page 4 currently lives in Washington State and she is unable to visit the resident often. She stated the resident did not exhibit any behaviors prior to admission to the nursing facility in June 2012. She indicated while the resident was at the psych hospital, he/she did not exhibit behaviors as alleged in the nursing facility. She revealed the resident had an extended stay at a psych hospital from 09/05/12 to 09/17/12 and 10/30/12-11/16/12 that used up all the resident's bed-hold days. Refer to F 205. She stated the facility called and told her they were not going to readmit the resident during one of the November admission, but then changed their mind and did re-admit the resident. She said she had not received a written notice of transfer or discharge that time either. In fact, the daughter indicated this was the first written transfer/discharge notice she had received. The Administrator was interviewed again, on 12/06/12 at 11:20 AM, that revealed the facility failed to provide a written notice of transfer or discharge for any of Resident #1's transfers to the hospital. She stated she thought the transfer notices were provided for the previous transfers; however, she could not find documented evidence they were. She stated staff were not consisted with providing transfer notices. She acknowledged she had spoken with the daughter sometime in November regarding the resident's behaviors. The Administrator stated the resident had begun to wander into other residents' rooms, became resistant of care, and combative with staff when care was provided. She told the hospital that the nursing facility was not going to accept the resident back. However, the Ombudsman visited the nursing facility and	F 203		

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F 203	Continued From page 5 informed the Administrator she had received a complaint alleging the facility was dumping the resident. The Ombudsman informed the Administrator of the resident's rights and request the nursing facility to readmit the resident. The facility agreed. The Administrator stated the transfer/discharge notice for the 12/03/12 transfer was provided on 12/05/12, after surveyor intervention.	F 203		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's bed-hold policy, it was determined the facility failed to provide written information	F 205	1. Resident #1 was discharged from the center on 12/3/12 and is currently receiving care at an inpatient facility. The center will re-evaluate resident for possible readmission to the center when resident is ready for discharge from the inpatient facility. The responsible party was provided with the Transfer/Discharge notice on 12/5/12 by the Administrator.	

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F 205	Continued From page 6 regarding the bed-hold policy prior to a transfer for one (1) of six (6) sampled residents and four (4) unsampled residents. Resident #1 was transferred from the nursing facility to a hospital for psych services on 09/05/12, 10/30/12, 11/16/12 and 12/03/12 without written notice of bed-hold information. The findings include: Review of the facility's policy titled, Transfer/Discharge & Bed-Hold Notices, effective date December 2009, revealed the facility would provide written information regarding this policy during the admission process and again at the time of transfer for hospitalization. If the facility determines that a transfer or discharge of a resident is required, the facility would abide by all applicable requirements, including provision of adequate notice to the resident/legal representative. The policy stated in case of an emergency transfer, the nurse would send the bed-hold notice to the hospital with the resident. The policy stated the resident is permitted to return and resume residence in the center. The administrator will ensure if the hospitalization or therapeutic leave exceed the bed-hold period, the resident would be readmitted to the next available bed. Review of a blank copy of the facility's bed-hold notice revealed all residents or responsible party can request a bed-hold while absent from the facility. Bed-hold for days of absence in excess of the state's bed-hold limit (14 days per year) are considered non-covered services. The authorization form had payor types of Medicaid, Medicare, Private, and other.	F 205	2. The Social Services Director educated residents in attendance at the Resident Council meeting on 1/8/13 regarding the center policy on Transfer/Discharge notice. The Social Services Director educated responsible parties at the Family Council meeting on 1/8/13 regarding the center policy on Transfer/Discharge notice. The Administrator sent a letter to current resident's responsible parties on 12/28/12 to inform them of the center policy and responsibility regarding Transfer/Discharge notice. Residents who had encountered a transfer or discharge within the past 30 days were reviewed by the Director of Nursing on 1/9/13 to determine if notice of Transfer/Discharge had been provided. A copy of the Transfer/Discharge notice was provided to 5 residents/responsible parties that had not previously received on 1/9/13 by the Social Services Director. 3. As of 12/28/12, the Administrator, Director of Nursing, and Social Services Director were re-educated by the Manager of Clinical Operations regarding the policy on Transfer/Discharge notice.	

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F 205	Continued From page 7 Review of Resident #1's closed clinical record revealed the facility admitted the resident on 06/01/12 with diagnoses of Alzheimer's Disease, Attention or Concentration Deficit, Frontal Lobe and Executive Function Deficit, Diabetes, Depressive Disorder, and history of Traumatic Brain Injury from a motor vehicle accident in 2007. The clinical record revealed the resident was transferred to a hospital for treatment on 09/05/12, 10/30/12, 11/27/12, and 12/03/12. The clinical record revealed no documented evidence a written notice of bed-hold information was provided to the resident or responsible party prior to transfer from the facility. Interview with Resident #1's daughter, on 12/05/12 at 5:45 PM, revealed she had just received a faxed copy of a notice of transfer/discharge & bed-hold about an hour ago. The daughter stated she had not received a bed-hold notice prior to the resident's transfer to the hospital on 12/03/12 and was not given the opportunity to hold the resident's bed. Interview with the Administrator, on 12/06/12 at 11:20 AM, revealed she had checked Resident #1's clinical record and could not find where a bed-hold notice was provided to the resident or the responsible party for the November transfers to the hospital or the 12/03/12 transfer. She stated she had spoken with the unit manager who acknowledged the bed-hold notices were not provided consistently. The administrator indicated the resident had exceeded the Medicaid bed-hold days (14 for hospital stay) and the facility thought they did not have to provide a bed-hold notice. However, the resident/responsible party were not	F 205	Licensed Nurses will be re-educated by the Administrator, Director of Nursing, and/or Assistant Director of Nursing regarding the policy on Transfer/ Discharge notice and the requirement to send written information with the resident or responsible party during a transfer/discharge by 1/19/13. An evaluation will be given after the education to validate staff understanding. When a transfer or discharge from the center is necessary the center will provide written information regarding the Transfer/Discharge policy. In addition, the center Administrator or Social Services Director will provide a follow up phone call to the transfer/discharge resident's responsible party to ensure written notices have been received and/or to review them and answer any questions if needed. 4. The Social Services Director began tracking each resident transfer and discharge as of 12/28/12 to determine that written information regarding Transfer/Discharge policy had been provided and that the follow up phone call had been completed. The Administrator/Social Services Director will discuss the results of this tracking monthly for three months and then at least quarterly at the Performance Improvement Committee meeting for further review and recommendations.	

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F 205	Continued From page 8 given the opportunity to pay for a bed-hold when the resident was transferred to the hospital. The administrator confirmed a bed-hold notice was not given to Resident #1 and the facility failed to always give bed-hold notice prior to transferring a resident to the hospital.	F 205	5. Completion date 1/20/13	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to revise the care plan to reflect current behavioral status for one	F 280	1. Resident #1 was discharged from the center on 12/3/12. 2. Residents that receive psychoactive medications and/or residents who were assessed by their most recent MDS to have behaviors were reviewed by the IDT on 12/10/12. Care plans and CNA Care Cards were updated to reflect behavior changes and to include any additional interventions as needed by Nursing Administration as of 12/10/12. 3. Licensed Nurses and CNAs will be re-educated by the Director of Nursing and/or Assistant Director of Nursing on the center's Behavior Management Program including updating/revising resident care plans and CNA Care Cards for behavior changes and interventions to address such behaviors by 1/19/13. An evaluation will be given after the education to validate staff competency.	

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F 280	Continued From page 9 (1) of six (6) sampled residents. Resident #1 had multiple behavioral changes with three (3) hospitalization at a Psych hospital for treatment without the care plan revised after those changes. Refer to F-323. The findings include: The facility utilized the Resident Assessment Instrument (RAI) process for care plan development and revision. Review of Resident #1's closed clinical record revealed the facility admitted the resident on 06/01/12 with the following diagnoses: Alzheimer's Disease, Attention or Concentration Deficit, Frontal Lobe and Executive Function Deficit, Diabetes, Depressive Disorder, and history of Traumatic Brain Injury from a motor vehicle accident that occurred in 2007. Review of the admission comprehensive assessment, dated 06/08/12, revealed the facility identified Resident #1 to have a cognition impairment, and able to ambulate independently with no behaviors identified. A comprehensive care plan was developed for wandering behaviors/elopement risk on 09/30/12. Review of the care plan revealed a goal that the resident would not wander from a secure location unattended. The care plan stated to allow Resident #1 to wander freely in a secure environment. In October and November 2012, the resident started wandering into other residents' rooms; however, the care plan was not revised to reflect this change. The clinical record revealed the resident received treatment at an outside Psych hospital 09/05-14/12, 10/30/12-11/16/12, 11/26-30/12, and 12/3/12. However, the care plan was not revised	F 280	4. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers will review the 24 Hour Report of Resident Change in Condition, Physician's Orders, and Behavior Monitor Flow sheets each day Monday-Friday to determine if behavior changes have occurred and validate care plans and CNA Care Cards were updated as necessary. Any identified issues will be addressed immediately. The Director of Nursing and/or Assistant Director of Nursing will track and trend any instances when behavioral changes had occurred and care plans and CNA Care Cards not updated or revised and report this to the Performance Improvement Committee monthly for three months, then at least quarterly further review and recommendation. 5. Completion date 1/20/13.	

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F 280	Continued From page 10 to reflect any behavioral or medication changes. On 12/03/12, the resident entered Resident #2's room and attempted to hit that resident. Instead Resident #2 hit Resident #1 causing minor injury. The care plan was not revised. Refer to F323. Interview with the MDS (Minimum Data Set) Coordinator, on 12/06/12 at 3:15 PM, revealed a staff nurse had developed the care plan regarding wandering risk on 09/30/12. However, the care plan only addressed elopement risk from the building. She said when the resident started to exhibit wandering behaviors, the staff nurses should have revised the care plan to reflect those changes. She stated the Interdisciplinary team (IDT) are only responsible for reviewing the care plan quarterly and if any changes occur outside those quarterly reviews, the staff nurses are suppose to revise the care plan. She stated interventions for wandering residents would be to monitor the resident and remove the resident when found in other residents' rooms. When asked if supervision was increased after the resident returned from the Psych hospital, she replied, "No."	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. Resident #1 was discharged from the center on 12/3/12. Resident #6 was reviewed by the IDT on 12/10/12 to validate care plan and CNA Care Card was updated and included interventions that may prevent resident behaviors including altercations between the resident and others.	

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	185364		C 12/06/2012

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 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide adequate supervision to prevent physical contact between two residents (hitting, causing minor injury to one of the residents) for four (4) of six (6) sampled residents and four (4) unsampled residents. The facility failed to adequately supervise Resident #1, who exhibited wandering behaviors, from entering Resident #2's room and threatening the resident. Resident #2 was provoked and struck Resident #1 resulting in a laceration to the resident's left eyebrow. The staff was unaware Resident #1 had wandered into Resident #2's room. Resident #6 wandered into Resident #4's room and slapped the resident. The findings include: Review of the facility's policy for prohibition of abuse, effective date of January 2008, revealed residents must not be subjected to abuse by anyone including other residents. Resident to resident altercations is an incident involving a resident who inflicts injury upon another resident. Under the section for resident to resident altercations, the policy denotes the Interdisciplinary team (IDT) are responsible for screening residents for behaviors that may make them more likely to be involved in an altercation. The IDT team should review the resident's assessment and identify interventions to prevent altercations. A care plan should be developed that include measures to ensure the safety of other residents. The facility will conduct ongoing staff training and supervision including how to approach a resident who may be agitated,	F 323	2. Residents that receive psychoactive medications and/or residents who were assessed by their most recent MDS to have behaviors were reviewed by the IDT on 12/10/12 to determine if the resident's behaviors increased the risk of situations/altercations with others. If indicated during this review, the IDT identified interventions that may prevent such altercations and updated care plans and CNA Care Cards to include these measures to help ensure the safety of others. 3. Center staff, nursing and non-nursing, will be re-educated by the Administrator, Director of Nursing, and/or Assistant Director of Nursing on the center's Abuse Prohibition Policy and Behavior Management Program to include identifying resident behaviors that may affect others, use of the care plan and CNA Care Card for behavioral management interventions that may prevent altercations from occurring/reoccurring, strategies to decrease likelihood of altercations, how to respond in the event of any altercation, and the reporting resident altercations to center Administrator immediately by 1/19/13. An evaluation will be given after the education to validate staff competency.	

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F 323	Continued From page 12 combative, physically aggressive, or anxious. The IDT team identifies factors that could trigger an altercation. The Administrator ensures that events will be identified, investigated, and reported to the appropriate authorities per state/federal regulation. 1. Review of Resident #1's closed clinical record revealed the facility admitted the resident on 06/01/12 with the following diagnoses: Alzheimer's Disease, Attention or Concentration Deficit, Frontal Lobe and Executive Function Deficit, Diabetes, Depressive Disorder, and history of Traumatic Brain Injury from a motor vehicle accident that occurred in 2007. The clinical record revealed a wander guard bracelet was applied on 06/02/12 due to risk for elopement identified on the assessment form. Review of the admission comprehensive assessment, dated 06/08/12, revealed the facility identified Resident #1 to have a cognition impairment, and was able to ambulate independently with no behaviors identified. Review of a nurse's note, dated 06/08/12, revealed the resident was ambulating throughout the facility. The note stated the resident required cueing for redirection. On 06/22/12, the nurse documented the resident required constant supervision. A comprehensive care plan was developed for wandering behaviors/elopement risk on 09/30/12. Review of the care plan revealed a goal that the resident would not wander from a secure location unattended. Interview with the Administrator, on 12/06/12 at 11:20 AM, revealed the facility did not have a locked-secured unit. She considered the whole building to be a secure location with a code alarm	F 323	4. Altercations involving a resident and others will be reviewed by the center Safety Committee within 72 hours of event to complete a root cause analysis and validate that appropriate safety interventions and precautions have been implemented to assist in the prevention of future situations. Any identified concerns will be addressed immediately. The Safety Committee Chairperson will report on these reviews monthly for three months and then at least quarterly to the Performance Improvement Committee meeting for further review and recommendation. 5. Completion date 1/20/13.	

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F 323	Continued From page 13 on all exit doors. Review of the kardex form dated November 2012 revealed the staff was instructed to redirect Resident #1 if observed going in and out of other residents rooms. Continued review of the clinical record revealed the resident was transferred to a Psych hospital for treatment on 09/05/12 to 09/1612, 10/30/12 through 11/16/12, 11/27/12-11/30/12, and 12/03/12. Review of the nurses notes revealed the resident began exhibiting aggressive behaviors on 09/21/12 during care. The resident continued to resist care and become agitated on 09/26/12, 09/27/12, and 10/09/12. The resident tried to hit a Certified Nursing Assistant (CNA) on 09/27/12 and grabbed a nurse's arm on 10/09/12. On 10/14/12, the nurse documented the resident was wandering throughout the facility. On 10/12/12 and 10/19/12, the resident wandered into another resident's room and staff had to remove the resident. The resident became agitated when staff tried to re-direct from the room. On 10/30/12, the resident shoved a visitor against the dining room wall and was transferred to the Psych hospital for treatment. Upon the resident's return on 11/16/12, the resident was observed wandering into other resident's rooms. On 11/17/12, Resident #1 wandered into another resident's room that was located on the 100 Unit (Resident #2 resided on the 200 Unit). When the nurse tried to redirect the resident, the resident attempted to hit the nurse. On 11/22/12 at 6:30 PM, the resident was observed to placed his/her hands on top of another resident's head and began shaking. When staff intervened, Resident #1 became agitated and required Haldol and Valium injections to help calm the resident. The	F 323		

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F 323	Continued From page 14 record revealed the resident required another dose of Valium at 10:00 PM because the resident was wandering into other residents' rooms and became agitated when staff tried to redirected the resident from the room. On 11/26/12, a CNA alleged the resident attempted to stick a pen in his back after giving care. The resident was transferred to the Psych hospital for treatment. The resident was readmitted to the facility on 11/30/12. Review of the nurses notes for 12/01/12 revealed the resident continued to wander into other residents' rooms and attempts to redirect the resident was unsuccessful. In addition, documentation revealed the resident was now showing aggression toward other residents, but had not made physical contact. On 12/03/12, Resident #1 wandered into Resident #2's room without staff's knowledge. Resident #1 attempted to hit Resident #2 several times but did not make contact. Resident #2 then hit Resident #1 causing a laceration to the resident's left eyebrow. The staff was not aware of the altercation until they heard a loud noise from the room. Resident #1 was removed and transferred to the Psych hospital for treatment. Resident#1 has been discharged from the facility and unavailable to be interviewed. Interview with Resident #2, on 12/05/12 at 2:20 PM, revealed he/she was previously a roommate with Resident #1. The resident stated Resident #1 would wander throughout the building and go into other residents' rooms. Resident #1 had wandered into Resident #2's new room several times prior to the incident on 12/03/12. The	F 323		

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F 323	Continued From page 15 resident stated Resident #1 would usually come into the room and stand by his/her bed. The resident would tell Resident #1 that this was not his/her room and the resident would usually leave without incident. Resident #2 stated on 12/03/12, Resident #1 looked different. The resident appeared more agitated and would not leave the room. Resident #1 became upset and began swinging his/her fist toward Resident #2 but missed hitting the resident. The resident stated Resident #1 attempted to hit him/her three times and they blocked the attempts. Resident #2 then hit Resident #1 causing a laceration to the resident's left eyebrow. He/she said Resident #2 starting bleeding. The resident said to Resident #1, "Look at you now." "You are bleeding." The resident stated he/she thought the ring on their pinkie finger may have caused the injury. Resident #2 then rang the call light and staff removed Resident #1 from the room. Review of Resident #2's most current cognition assessment completed on 09/13/12 revealed a BIMS score of 15. Interview with Resident #3 (roommate to Resident #2), on 12/05/12 at 2:20-2:40 PM, revealed he/she had witnessed the altercation between Resident #1 and Resident #2. Resident #3 stated Resident #1 had wandered into their room before but usually would leave when asked. On 12/03/12, Resident #1 came into the room and walked over to Resident #2's bed. Resident #2 asked the resident to leave because this was not his/her room. The resident overheard Resident #1 tell Resident #2 that he was going to kill him/her. Resident #1 then drew back his/her fist and attempted to hit Resident #2. The resident tried several times but Resident #2	F 323		

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F 323	Continued From page 16 blocked the attempts. Then Resident #2 struck Resident #1 with his fist while telling him/her to leave. The resident began to bleed. The noise was loud, then the staff came in and removed Resident #1. The resident stated he/she was not afraid. Interview with the 200 Unit Nurse Manager, on 12/05/12 at 4:45 PM, revealed she did not witness the altercation (no staff witnessed) between Resident #1 and Resident #2 on 12/03/12. She stated CNA#1 notified her of the incident and she went to Resident #2's room and interviewed the residents. The CNA had already removed Resident #1. She stated Resident #2 told her that Resident #1 came in an tried to hit him/her. The resident tried to block Resident #1's hands and hit the resident as a result. She stated Resident #1 required first aid treatment related to a laceration to the left eyebrow. Resident #1 was placed on 1:1 supervision until the resident was transferred to a Psych hospital for treatment. The nurse manager stated Resident #1 wandered about the facility and when the staff observe the resident in another resident's room, they are to remove him/her. She stated Resident #1's wandering appears to be without purpose and he had not hit another resident before this incident. However, the clinical record revealed the resident shook another resident's head on 11/22/12. She stated the staff attempt to monitor the resident's whereabouts; however, the resident is not on 1:1 supervision. She stated the staff would remove the resident from other residents' rooms when observed. Interview with the Assistant Director of Nursing (ADON), on 12/05/12 at 5:00 PM, revealed she	F 323		

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

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 C 12/06/2012
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 323	Continued From page 17 was on the 200 Unit when the incident occurred but she did not witness the altercation. She stated she was informed by CNA #1 that Resident #1 went into Resident #2's room and attempted to hit the resident. Resident #2 hit Resident #1 when he/she tried to block the resident's attempts to hit him/her. The ADON revealed she took Resident #1 to the nurses station without any problems and first aid was provided. She stated the resident had wandered into Resident #2's room before and wandered throughout the facility, including her office. She indicated it was a group effort to monitor the resident's whereabouts. She said if staff observe Resident #1 in other residents' rooms, they are instructed to stop and redirect the resident from the room. If staff had seen Resident #1 enter Resident #2's room, the staff would have removed the resident. This probably would have prevented the altercation. She indicated there was no increased supervision provided for Resident #1 upon readmission to the facility on 11/30/12. Interview with CNA #1, on 12/05/12 at 5:15 PM, revealed she had just left Resident #2's room shortly before the altercation occurred. She did not witness the altercation. Resident #2 activated the call light and she was responding when she heard yelling. When she went into the room, Resident #2 told her he/she had struck Resident #1 because the resident was attempting to strike him/her. Resident #1 had a small cut on the face. She indicated Resident #1 has wandered into other residents' rooms before and this was no new occurrence. She stated staff could not prevent Resident #1 from wandering into other residents' rooms. If the staff observe Resident #1 in other rooms, they are to redirect the resident	F 323		

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F 323	Continued From page 18 from the room. She indicated there was no increase supervision for Resident #1 upon the resident's return to the nursing facility. We stated staff could not watch the resident at all times. Interview with CNA #2, on 12/05/12 at 5:30 PM, revealed she was on break when the altercation between the residents occurred. She indicated she had worked the 200 Unit many times and was familiar with Resident #1's wandering behaviors. She stated Resident #1 would often wander into other residents' rooms. She said the staff try to watch for the resident; however, you get busy and cannot watch the resident at all times. Interview with unsampled Resident A, on 12/06/12 at 12:45 PM, revealed Resident #1's room is next door to this resident's room. Resident #1 wandered into the resident's room almost daily without staff's knowledge. He/she stated Resident #1 walked the hallway all the time and would use other resident's bathroom. Whenever Resident #1 came into his/her room, the resident would tell Resident#1 this was not his/her room and usually the resident would leave. This resident stated she did not trust Resident #1 because the resident was so confused and he/she had heard Resident #1 had hit other residents. Although Resident #1 had never threatened or hit this resident, he/she expressed fear of Resident #1. Interview with Unsampled Resident B and C (roommates), on 12/06/12 at 1:00 PM, revealed they knew Resident #1 by name and wandered into their room frequently. Normally, they would tell the resident to leave and he/she would.	F 323		

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F 323	Continued From page 19	F 323		

Unsampled Resident C stated he/she awakened one night to find Resident #1 standing at the foot of the bed, starring. The resident told Resident #1 to leave. The resident hiked his/her leg and looked like he/she was going to do a karate kick. This resident yelled out for the staff and they came to remove Resident #1. The resident stated "I believe he/she could really hurt a person."

Interview with Unsampled Resident D, on 12/06/12 at 2:40 PM, revealed his/her room was on the 100 Unit; however, the resident was visiting on the 200 Unit when Resident #1 just came up and started shaking his/her head. Although the unsampled resident did not get hurt, they did not like having their head shook like that.

Interview with the Director of Nursing (DON) on 12/06/12 at 6:45 PM, revealed Resident #1's wandering behaviors had been identified and a care plan had been developed to address that problem. The resident required continuous verbal cues and supervision. However, the DON stated 1:1 supervision was not provided. She stated when staff observe Resident #1 in another resident's room, they are to remove the resident. She confirmed the facility had not increased supervision of Resident #1 after three hospitalizations, and multiple documented episodes of the resident wandering into other residents' rooms. The DON stated Resident #1's behaviors had escalated and she was afraid the resident was going to hurt another resident.

Interview with the Administrator, on 12/06/12 at 11: 20 AM, revealed the resident's behaviors had increased and the facility felt they could no longer meet the resident's needs; therefore, the decision

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F 323	Continued From page 20 was made to not accept the resident back for readmission when the resident was ready for discharge from the Psych hospital. 2. Interview with Resident #4 during tour of the facility, on 12/05/12 at 1:45 PM, revealed there were a few residents who had wandered into the resident's room. The residents would usually leave when he/she asked them to leave. However, one resident did not leave and slapped the resident in the face. Resident #4 stated there were no injuries and the other resident had not been in his/her room since. Review of Resident #4's clinical record revealed the facility had admitted the resident on 09/06/12 for rehab services. Review of the nurses notes dated 10/28/12 revealed the resident reported to a CNA that Resident #6 had wandered into his/her room and slapped the resident in the face. A physical assessment was conducted and three (3) red marks were noted on the resident's right cheek. The right ear appeared to be red also. The resident denied pain. Review of the most current assessment revealed no cognition impairment with a Brief Interview Mental Status (BIMS) score of fifteen (15). Review of Resident #6's clinical record revealed the facility admitted Resident #6 on 08/12/11 with diagnosis of Cognition/Communication Deficit. The facility identified the resident to have wandering behaviors. Review of the nurses note dated 10/28/12 revealed the resident wandered into Resident #4's room and slapped the resident. The incident was not witnessed by staff. Both residents were assessed and Resident #6 was removed from the room and taken to his/her	F 323		

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F 323	Continued From page 21	F 323		
	room. The staff attempted to interview the resident; however, the resident could not recall the incident. Review of the resident's most current assessment, dated 11/07/12, revealed the facility assessed the resident to be severely impaired with decision making and had a cognition impairment. Review of the comprehensive care plan, dated 2/14/12, revealed a goal for the resident to propel the wheelchair safely and to remove the resident from any area that the resident had entered that was not appropriate. On 10/28/12, the care plan was revised that stated the resident entered another resident's room by accident. The goal was to be free from injury and intervention included removal of resident from the area and provide diversional activities. Interview with the Director of Nursing, on 12/06/12 at 6:45 PM, revealed Resident #6 wandered on the unit with no purpose. The resident wandered into Resident #4's room and when the resident requested him/her to leave, he/she hit the resident. The staff was unaware of the incident until Resident #4 reported it. She stated the staff are suppose to monitor the resident's whereabouts and remove wandering residents from other residents' rooms when observed. Observation of Resident #6, on 12/06/12 at 7:00 PM revealed the resident lying in bed with eyes closed. Observation during the survey of other residents identified by the facility with wandering behaviors, revealed the residents did not wander into other residents rooms.			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514	1. Resident #1 was discharged from the center on 12/3/12.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185364		C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENTON MANOR CARE AND REHABILITATION CENTER	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 514	Continued From page 22 LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the clinical record was completed with accurate documentation for one (1) of six (6) sampled residents. Resident #1 exhibited multiple behaviors and was given additional Psych medications to control those behaviors. However, the facility failed to document the behaviors on the Behavior Monthly Flow Sheet with no documented evidence Psych medications were monitored. The findings include: The facility did not provide a policy for documentation in the clinical record. Interview with the Director of Nursing (DON), on 12/06/12 at 6:45 PM, revealed the facility utilized monthly behavioral flow sheets to documente	F 514	2. Residents that receive psychoactive medications and/or residents who were assessed by their most recent MDS to have behaviors were reviewed by Nursing Administration on 12/10/12 to determine if the resident's Behavior Monitoring Flow sheet and Side Effect Monitoring Flow sheet were in place and that target behaviors were appropriately identified on the flow sheet. 3. Licensed Nurses will be re-educated by the Director of Nursing and/or Assistant Director of Nursing on monitoring residents for behaviors and side effects of psychoactive medications; and to document the behaviors on the Behavior Monitor Flow sheet and to document any side effects on the Medication Side Effects Flow sheet by 1/19/13. Center staff, nursing and non-nursing, will be educated by the Director of Nursing and/or Assistant Director of Nursing by 1/19/13 to report resident behaviors to the licensed nurse so that interventions may be further implemented as needed and documentation can be completed by the	

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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 514	Continued From page 23 identified behaviors. Resident #1's identified behaviors included: wandering, agitation, resistive to care, and playing in feces. She stated the behavioral monitoring sheets are to be filled out each time the resident exhibited those targeted behaviors. In addition, the resident was on medications that require monitoring for side effects. That documentation was suppose to be placed on the side effect flow sheet. Review of the flow sheet revealed the staff monitored four types of medication classes: Antianxiety, Antidepressant, Antipsychotic, and Sedative/Hypnotic. Review of Resident #1's closed clinical record revealed the facility admitted the resident on 06/01/12 with diagnoses of Alzheimer's Disease, Attention or Concentration Deficit, Frontal Lobe and Executive Function Deficit, Depressive Disorder, and history of Traumatic Brain Injury from a motor vehicle accident in 2007. The clinical record revealed the resident was transferred to a Psych hospital for treatment on 09/05/12, 10/30/12, 11/27/12, and 12/03/12. Review of the care plan developed on 09/17/12 revealed the facility was to document behaviors/interventions as indicated. Review of the monthly behavioral flow sheet for September 2012 revealed the target behaviors to be monitored were compulsive and wandering. Continued review of the September behavior flow sheet revealed the compulsive behaviors were identified on September 4, 5, 18 and the wandering behaviors were identified on the 4 th, 5 th, 18 th, and 19 th. However, review of the clinical record (nurses' notes) revealed Resident #1 exhibited the following behaviors:	F 514	licensed nurse on the Behavior Monitor Flow sheet. An evaluation and example of documentation will be conducted after the education to validate staff competency. 4. The Director of Nursing, Assistant Director of Nursing and/or the Unit Managers will review Behavior Monitor Flow sheets and Side Effect Flow sheets each day Monday-Friday to validate completion of the Behavior Monitor Flow sheet and Medication Side Effect Flow sheet and track and trend any missed documentation. Any identified issues will be addressed immediately. The Director of Nursing and/or Assistant Director of Nursing will report the trends to the Performance Improvement Committee monthly for three months then at least quarterly for further review and recommendation. 5. Completion date 1/20/13.	

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F 514	Continued From page 24 09/04/12-removed pants and brief and smeared feces all over the bathroom x 3, 09/05/12, the resident urinated in the floor. The record revealed the resident was transferred to a Psych hospital for treatment 09/05/12 through 09/14/12. Upon the resident's return, the resident exhibited these behaviors: 09/21/12-resisted care, 09/26/12-became very agitated during care, 09/27/12- the resident resisted care and raised a fist to strike at staff. These behaviors were not documented on the behavior monthly flow sheet. In addition, review of the medication side effect monitoring flow sheet for September 2012 revealed only four (4) of thirty (30) days were documented. Review of the October 2012 behavior flow sheet revealed the form was blank with no documentation. Review of the nurses' notes revealed the resident exhibited behaviors eleven days with the resident transferred to a Psych hospital on 10/30/12 for treatment of aggressive behaviors where the resident shoved a family member against the wall in the dining room. In addition, the medication side effect flow sheet was blank with no evidence the facility monitored Resident #1's medications. Review of the November 2012 behavior flow sheet and the medication side effect flow sheet revealed the forms were blank with no documentation of any behaviors or evidence of monitoring the resident's medications. The clinical record revealed the resident did exhibit behaviors and required another transfer to the Psych hospital on 11/26/12 for aggressive behaviors. In addition, the resident continued to wander into other resident's rooms. However, this was not	F 514		

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F 514	Continued From page 25 documented on the behavioral monthly flow sheet. The facility could not find the December behavior flow sheet nor the medication side effect flow sheet. The resident was transferred to the Psych hospital on 12/03/12 after wandering into another resident's room and attempting to strike that resident. Continued interview with the DON, on 12/06/12 at 6:45 PM, revealed she had identified there was a problem with completion of the behavior monitoring flow sheets and medication side effect flow sheets. She stated the nurses were not documenting residents' behaviors and monitoring medications as they should be. She confirmed these flow sheets were part of the clinical record and should be completed whenever a behavior occurred.	F 514		

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