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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	185325		R 10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAL TURNER REHAB AND SPECIALTY CARE	456 BURNLEY RD. SCOTTSVILLE, KY 42164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 10/07/15, as alleged.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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

PRINTED: 10/01/2015
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
	185325	A. BUILDING _____ B. WING _____	09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAL TURNER REHAB AND SPECIALTY CARE	456 BURNLEY RD. SCOTTSVILLE, KY 42164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertificarion Survey was conducted on 09/16/15 through 09/18/15 with deficient practice identified at the highest Scope and Severity of a "D".	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure services provided met professional standards of care for one (1) resident (#13), in the selected sample of twenty-two (22) residents, who was prescribed a Lidocaine pain patch for twelve (12) of twenty-four (24) hours a day. During a Medication Administration observation on 09/16/15, the resident was wearing a Lidocaine Patch, dated 09/13/15. In addition, review of the Medication Administration Record (MAR) revealed the patch had been initialed as removed, on three (3) evening shifts, dated 09/13/15 through 09/15/15. The findings include: Review of the facility's policy and procedure titled, "Administration of Medication," dated February 2005, revealed "Each dose of medication administered shall be properly recorded on the Electronic Medication Administration Record (eMAR.) The licensed nurse or Certified	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacqueline H. Woodward	Administrator	10/15/15

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.

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

PRINTED: 10/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185326		09/18/2015

NAME OF PROVIDER OR SUPPLIER: CAL TURNER REHAB AND SPECIALTY CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 456 BURNLEY RD. SCOTTSVILLE, KY 42164

(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 281	Continued From page 1 Medication Technician (CMT) should check the MAR for the resident's name, physician's name, name and strength of the medication, dosage instructions and directions for administration". Record review revealed the facility admitted Resident #13 on 03/16/15 with diagnoses to include a History of Head Trama and Intracranial Injury from a fall in 2012, Bilateral Above the Knee Amputations (BKA), and Chronic Pain. Review of a physician's order, dated 08/26/15, revealed a Lidoderm Five (5) percent (%) Patch was to have been applied to the resident's lower back, topically, one (1) time a day for pain, and the staff were to leave the patch on for twelve (12) hours and off for twelve (12) hours. Further orders revealed the patch was suppose to be removed at bedtime, after the resident had worn the patch for twelve (12) hours. Review of the eMARs, dated 09/13/15 through 09/15/15, revealed the night shift initialed the patch as having been removed. Observation during a Medication Administration Pass, on 09/16/15 at 9:03 AM, revealed Licensed Practical Nurse (LPN) #1 applied the Lidocaine patch to the resident's mid-back and failed to note an additional patch on the resident's lower back. Observation of the patch on the lower back revealed it was dated 09/13/15. Interview with LPN #1, on 09/16/15 at 1:50 PM, revealed she did not see the patch, as the resident was positioned up in the wheel chair, and his/her entire back was not viewed. She stated the old patch should have been taken off on 09/13/15 at 9:00 PM. She stated the resident becomes very hostile when attempts are made to	F 281	This plan of correction is offered as an attempt to provide the highest level of quality services possible to our residents and is not an admission that the deficiencies cited are correct. **F 281** 1 The LPN removed the Lidocaine pain patch from Resident # 13 on September 16, 2015. Assessment was completed on Resident #13 by our Unit Supervisor on September 16, 2015 with no findings of adverse action related to the delay in the removal of the Lidocaine pain patch. LPN #1 and LPN #2 were counseled by the Director of Nursing on September 16, 2015 to emphasize the importance of patch administration, to include a thorough skin assessment to ensure any previously administered patch is removed, and proper documentation related to the patch placement and removal. 2 On September 16, 2015 through September 23, 2015 the LPN and RN staff completed skin assessments on all residents who were administered transdermal patches. There were no findings of patches being overdue for removal.	

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

PRINTED: 10/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185326		09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAL TURNER REHAB AND SPECIALTY CARE	456 BURNLEY RD. SCOTTSVILLE, KY 42164

(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 281	Continued From page 2 assist him/her back to bed, where the entire back area can be viewed, and the new patch should have been placed on the resident's low back, as ordered by the physician. She also stated the resident had refused to have the Lidocaine patch applied, on the morning of 09/15/15, so there was no patch to remove on the night shift, yet this was also initialed as removed on the eMAR. Interview with LPN #2, on 09/16/15 at 2:00 PM, revealed she had placed the patch, dated 09/13/15, on the resident's low back at approximately 7:00 AM. The nurse stated she had worked a fourteen (14) hour shift that day and the resident was having behaviors and refused to lie down to allow the patch to be removed. This was reported to the next shift nurse, who agreed to remove the patch when the resident was assisted to bed that evening. However, LPN #2 initialed the patch as removed before she left the facility. Interview with the Director of Nursing (DON), on 09/18/15 at 2:35 PM, revealed the patch should have been removed on 09/13/15, as ordered. She also stated the staff should have verified correct placement of the patch, prior to the administration of another patch. She stated the eMAR should not have been initialed as completed, if the patch, dated 09/13/15, had not been removed.	F 281	3 On September16, 2015 the Director of Nursing and the Unit Supervisors started providing education sessions on the procedure for transdermal patch application, removal and documentation to all RN, LPN, and CMT staff. 4 Effective October 1, 2015 the Unit Supervisors will conduct a minimum 5 licensed staff observations per month on transdermal patch application, removal, and documentation to ensure professional standards of quality and compliance with the transdermal procedure. The results of the observations will be submitted to the Director of Nursing for a period of four consecutive months to ensure Performance Improvement. 5. Completion date for the deficiency 10/7/2015	10/7/2015

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
185325	CAL TURNER REHAB AND SPECIALTY CARE

Type of Survey (select all that apply)

I	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A	F			

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey
F offsite/Paper

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 18332			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 1.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 1.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

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

PRINTED: 10/01/2015
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
	185325	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAL TURNER REHAB AND SPECIALTY CARE	456 BURNLEY RD. SCOTTSVILLE, KY 42164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1992. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type II (111). SMOKE COMPARTMENTS: Six (6) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1992 with 21 smoke detectors and 5 heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1992. GENERATOR: Type II generator installed in 1992. Fuel source is Diesel. A standard Life Safety Code Survey was conducted on 09/16/15. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid, Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The facility is certified for one-hundred ten (110) beds with a census of one-hundred ten (110) on the day of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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