

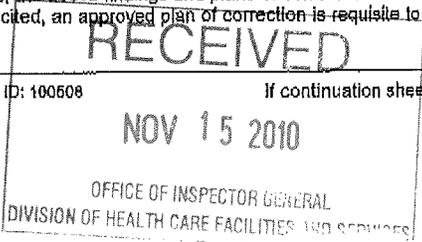
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2010
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 10/21/2010
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 000	INITIAL COMMENTS A standard health survey was conducted 10/19/10 through 10/21/10 and a Life Safety Code survey was 10/20/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated standard survey was initiated on 10/19/10 and concluded on 10/21/10 investigating KY00015399, KY00015196 and KY00015431. KY00015399, KY00015196 and KY00015431 were unsubstantiated with no deficiencies cited.	F 000	<i>This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies.</i>	
F 174 SS=E	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure that residents had reasonable access to the use of a telephone where their calls could be made without being overheard. Residents routinely used the nurse's station or the Joy Room to make personal telephone calls, and were not provided privacy during telephone conversations. The findings include: Observation on 10/21/10 at 8:20am revealed Resident #31, who utilizes a wheelchair, was in the 200 Joy Room/Dining Room requesting staff to dial her sister-in law's phone number. Resident #13 proceeded to talk on the telephone for 10	F 174	F174 1. Resident #31 and Resident #23 were satisfied with the right to have reasonable access to the use of the telephone where calls can be made without being over heard per interview on November 10, 2010. 2. All residents have the potential to be affected. 3. A new phone will be purchased by November 18 th , 2010 for resident use that has adaptive equipment for hard of hearing or seeing impaired residents. Also, privacy for residents phone use will be provided by lowering the resident phone in the joy room and providing a cordless telephone at each nurse's station that the residents will have access to without staff assistance. Staff to be re-educated by administrator/ADNS/Social Service Director by November 18, 2010 on new phones and providing privacy to residents during phone conversations.	11/19/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *x Gail Shum* TITLE *x Administrator* (X6) DATE *x 11/15/10*

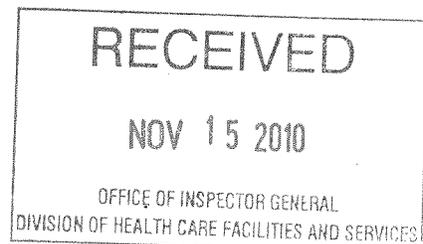
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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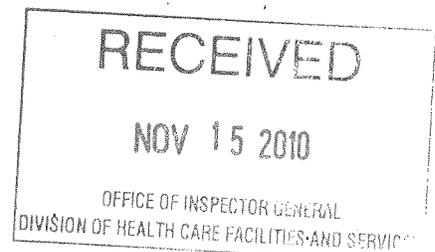
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F 174	<p>Continued From page 1</p> <p>minutes. During this 10 minutes period there were 3 staff and 2 surveyors while 10 residents ate breakfast within hearing distance of the resident 's conversation.</p> <p>An interview with Resident #31 on 10/21/10 at 8:30am revealed that the facility had a cordless phone for resident's use; but he/she is unable to hear on that phone. He/she further stated that the telephone in the Joy Room was not accessible to residents that use wheelchairs because of the height placement. Resident #31 stated that he/she would like to use the cordless telephone for private conversations but it would have to be equipped for hearing impaired residents.</p> <p>An interview with Resident #23 on 10/21/10 at 1pm revealed that due to the height placement and being unable to see the small phone numbers, Resident #23 always needed staff assistance. He/she further stated that if the staff were busy, you would need to wait until someone was available to assist you.</p> <p>Interview with RN #1 on 10/21/10 at 2pm revealed that the cordless phone had no adaptive equipment for hard of hearing or seeing impaired residents. She further stated that when the resident wants to make a call the staff will dial the number from the nurses' station and transfer the call to the Joy Room. RN #1 stated that due to the height of the telephone and no adaptive equipment for the hearing or seeing impaired, the resident would not have access to the telephone without assistance. She further stated that it would be uncomfortable for a resident to ask the staff to dial the ombudsman's phone number.</p> <p>Interview with the Activity Director on 10/21/10 at</p>	F 174	4. Administrator/DNS will monitor the above system to ensure residents satisfaction with phone availability and privacy by conducting resident interviews weekly. Results will be reported and discussed by the Administrator/DNS to monthly PI committee for review to ensure compliance monthly times three (3) months.	



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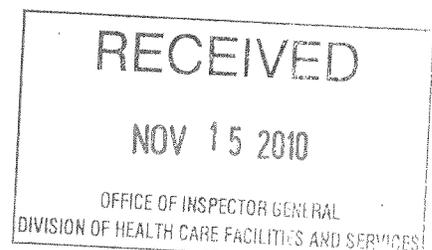
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F 174	Continued From page 2 1:30pm revealed that the telephones height on the 100 and 200 Joy Room was because residents would knock the telephone over. She further stated that the 100 Joy Room telephone was broke and was aware there was no hand set. Interview with the Social Service Worker (SSW) on 10/21/10 at 2:30pm revealed that on the 100 unit there were fifteen (15) residents with glasses and fourteen (14) with vision impairment, eight (8) residents with hearing impairment and one (1) with a hearing aid, thirty (30) residents in wheelchairs; on the 200 unit there were twenty-five (25) residents with glasses, two (2) residents with hearing impairment and thirty (30) residents in wheelchairs. She further stated that she had not looked into getting adaptive equipment for the telephone. SSW also revealed that she has assisted residents with making private calls in her office; however, it would be uncomfortable for a resident to ask for her assist with making a call to the ombudsman. Further evidence provided by the Administrator on 10/28/10 revealed that residents have access to a phone in the 100 Joy Room and activity room to make private calls. However, observations on 10/21/10 revealed the telephone located in the 100 joy room was not usable as it had no handset and the room was accessible to other residents and staff during the time phone calls would be made by residents.	F 174		
F 364 SS=B	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper	F 364	F364 1. Resident #7 and resident #8 were interviewed by food service manager on November 10, 2010 to ensure satisfaction of food and to obtain food preferences.	11/19/2010



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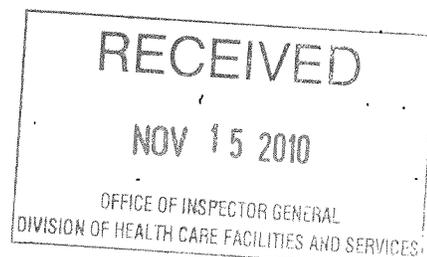
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F 364	<p>Continued From page 3 temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to provide food that was palatable and well seasoned as evidenced by the cabbage served on 10/20/10 at 5:30pm. The facility failed to follow the recipe approved by the dietician when preparing the cooked cabbage.</p> <p>The findings include:</p> <p>Observation of the meal service on 10/20/10 at 5:30pm revealed cooked cabbage was on the menu and was served to all residents.</p> <p>Interview with Resident #7 on 10/20/10 at 7:00pm, revealed the cabbage served at dinner had no taste and that food prepared by the kitchen frequently had no taste.</p> <p>Interview with Resident #8 on 10/19/10 at 4:45pm revealed the resident did not care for the food in general. She stated the food was not cooked long enough and had no flavor.</p> <p>Interview with the Food Service Manager on 10/21/10 at 10:00am revealed the recipe for cooked cabbage included salt, pepper, onion, and bacon. She stated in order to follow the recipe, staff would have to cook several batches of cabbage and leave out the bacon and possibly the salt for residents on restricted diets. She stated preparing several types of cabbage was too much work and the steam table would not hold the number of pans required. She stated the</p>	F 364	<ol style="list-style-type: none"> 2. All residents have the potential to be affected. 3. Menu items will be prepared per standardized recipes. Cycle menus will be followed per written extensions and reviewed monthly during food committee with residents. Dietary staff will be re-educated by November 18th, 2010 by the Food Service Manager/Administrator on following standardized recipes, following cycle menus per written extensions. 4. Food Service Manager/Cook/Administrator will test taste a test tray for palatability with meals. Results will be reported and discussed by the Food Service Manager/Administrator to the PI committee to ensure compliance times three (3) months. 		



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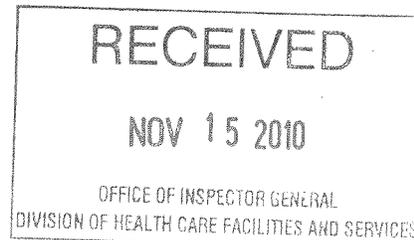
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F 364	Continued From page 4 facility did not season food so all residents could eat from one prepared batch of food even though food was to be cooked using the recipes approved by the dietician.	F 364		
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve and distribute food under sanitary conditions. Staff were observed to perform hand washing for as little as three (3) seconds and to turn off the water faucet with bare hands. A Dietary Aide (DA) was observed to pick up a tray card from the floor, place the card on a tray and load the tray onto the food cart going out to residents. The findings include: Observation of the meal service in the kitchen on 10/19/10 at 6:05pm revealed a paper tray card blew off a tray and landed on the floor. The DA picked up the tray card from the floor and placed it back on the tray which had a meal ready to be served to a resident. The DA then loaded the tray	F 371	F371 1. Employee who failed to serve and distribute food under sanitary conditions was educated on October 19, 2010 by the Administrator and DNS on hand washing procedures and serving and distributing food under sanitary conditions. 2. All residents have the potential to be affected. 3. Dietary Manager/Administrator re-educated the dietary staff on not placing items on tray after being dropped on floor and washing hands appropriately on November 4, 2010. Dietary staff were re-educated by Administrator on washing hands appropriately on November 4, 2010. The Dietary Manager will provide dietary staff with blank tray cards if the tray card dropped on floor. Pertinent information will be written on new tray card. 4. Dietary Manager/Administrator will monitor meal service 3 times weekly times 4 weeks; 2 times weekly times 2 months to ensure items dropped on floor are replaced and staff are washing hand appropriately. Re-education given by Dietary Manager/Administrator as needed to ensure compliance. Food Service Manager/Administrator will report results to the PI committee to ensure compliance times three (3) months.	11/19/2010



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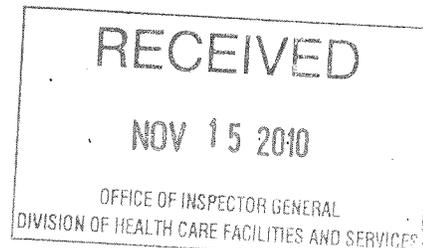
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F 371	Continued From page 5 onto a meal cart and sent the cart out to the resident unit to be served. The DA failed to wash her hands after picking up the tray card from the floor and failed to provide a clean tray card for the resident's tray. Continued observation of the meal service revealed the DA was washing her hands after delivering the meal carts to the resident units twice; however, she only washed her hands for three (3) seconds and turned off the water faucet with her bare hands. The DA failed to follow the facility policy to wash hands for fifteen seconds, rinse, dry, and then turn off the water faucet using a paper towel. Interview with the DA on 10/19/10 at 6:50pm revealed she was aware she should have washed her hands for the full fifteen (15) seconds; however, she did not remember what to do regarding turning the water faucet off with a paper towel. She stated she knew she should not have picked up the tray card from the floor and placed it back on the tray. She stated she had been trained on infection control and hand washing at an unknown date. Interview with the Food Service Manager on 10/21/10 at 10:00am revealed nothing should ever be picked up off the floor and placed on a resident's meal tray. She stated staff must wash their hands for fifteen (15) seconds and should always turn off the water faucet with a paper towel.	F 371			
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and	F 386	F386 1. Residents #2, 3, 7,8,12 and 15 orders will be signed by November 18, 2010.	11/19/2010	



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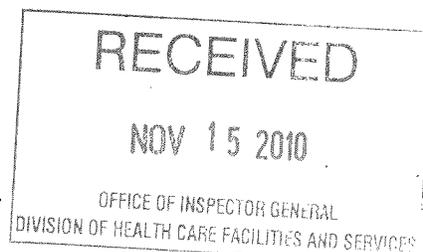
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F 386	<p>Continued From page 6</p> <p>treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of Influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure physicians reviewed six (6) of thirty-three (33) sampled residents (#2, #3, #7, #8, #12 and #15) total programs of care, including medications and treatments, at each visit and signed and dated all orders as required. The facility failed to have an effective system in place to monitor and ensure physician orders were signed timely.</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #3 revealed the resident was admitted with diagnoses of Dysphagia, Gastric Esophageal Reflux Disease and Seizures. Verbal orders received from the attending physician on 09/13/10 and 09/14/10 was unsigned.</p> <p>Review of the clinical record for Resident #7 revealed the resident was admitted with diagnoses of Chronic Obstructive Pulmonary Disease and Congestive Heart Disease. Verbal orders received from the attending physician on 09/30/10 were unsigned.</p> <p>Review of the clinical record for Resident #15 revealed the resident was admitted with</p>	F 386	<ol style="list-style-type: none"> An audit of all active Medical Records was completed by Administrator and Health Information Manager on November 4, 8 and 9, 2010. Any resident identified in needing orders signed will be signed and placed in their medical records by November 18, 2010. The Health Information Manager was re-educated by Administrator on November 9, 2010 on having orders signed timely and placed in medical record. The nurses will be re-educated by DNS/Unit Managers/ADNS on entering orders in PCC and copies needed by November 18, 2010. Health Information Manager will audit charts monthly for signing of orders and meeting with Administrator on finding. Health Information Manager will take any outstanding orders in need of signing to attending Physician or ARNP for signing. Administrator/ Director of Nursing will monitor five (5) residents' charts to ensure accuracy for specific resident times 2 times weekly times 4 weeks, weekly times 4 weeks and monthly thereafter. Administrator/DNS will report results to the PI committee to ensure compliance times three (3) months. 	



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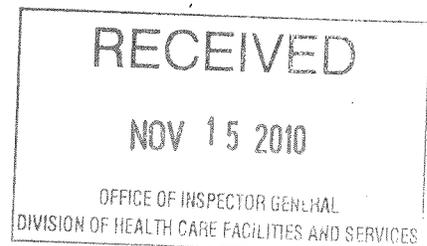
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F 388	<p>Continued From page 7</p> <p>diagnoses of Severe Mental Retardation and Dysphagia. Renewal orders dated 08/31/10 were unsigned.</p> <p>Review with Licensed Practical Nurse (LPN) #5 on 10/20/10 at 3:50pm revealed new orders received were entered into the computer then a copy of the unsigned order was placed on the chart and the original was placed in a book for the physician to sign. She stated the nurses were not responsible to have the orders signed and that task was managed by medical records staff.</p> <p>Interview with the Administrator on 10/21/10 at 2:00pm revealed the Health Information Manager (HIM) audited physician orders for signatures and audits revealed no problems. She stated the audit was not effective since orders were located that were not signed timely.</p> <p>Interview with the Director of Nursing on 10/21/10 at 2:10pm revealed she had never contacted the physician regarding unsigned orders for no particular reason.</p> <p>Attempts to interview the physician, also the facility's medical director, by telephone were unsuccessful.</p> <p>Record review for Resident #2 on 10/19/10 revealed physician orders dated 07/19/10 and 08/07/10 which had not been signed by an MD.</p> <p>Record review for Resident #8 on 10/19/10 revealed physician orders dated 07/17/10, 07/18/10, 07/19/10, 07/26/10, and 08/09/10 which had not been signed by an MD. Monthly physician orders for July and August had not</p>	F 388		



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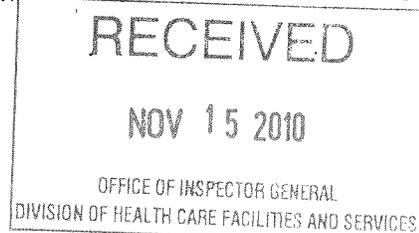
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F 386	<p>Continued From page 8 been signed by an MD.</p> <p>Record review for Resident #12 on 10/20/10 revealed physician orders dated 10/04/10 and 10/05/10 which had not been signed by an MD.</p> <p>Interview with Health Information Manager on 10/20/10 at 11:25am revealed the process for verbal orders included; verbal orders are taken and then entered into the PCC computer system, the nurses then make three copies, one for the MD book for signature, one for the unit manager and one to fax to pharmacy and then put in the resident's chart marked copy. The order marked copy stays in the resident's chart until the original order comes back with the physician's signature. The Information Manager stated she goes on the second and fourth Wednesdays to meet with the Medical Director to get unsigned orders signed, then comes back and puts them in the resident's charts. She stated that if the ARNP comes into facility that ARNP goes to MD book, signs any unsigned orders, and notifies her that ARNP was in building. The Information Manager stated the next morning she files the signed orders. She continued by stating that when verbal orders are missing signatures it could be due to copies not being made appropriately, copies not being put in MD book for signature or not being able to make contact with the MD or ARNP for signatures. She related that she was unaware of any regulations that indicated a timeframe in which verbal orders needed to be signed. She stated there are problems with this system and acknowledges that the medical records are incomplete without the required signatures.</p> <p>Interview with RN #1 on 10/21/10 at 2:35pm revealed that she receives a copy of verbal orders</p>	F 386		



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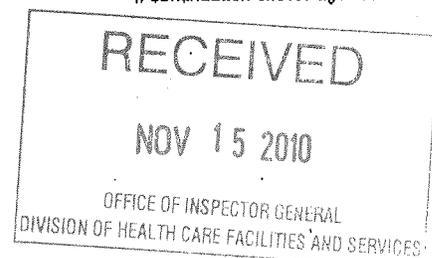
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 9 each day. She reviews those new verbal orders in morning meetings with staff. She revealed that she does not track those verbal orders to see that they are signed in a timely manner. She stated that there is a problem with unsigned orders and the Administrator has talked to the Medical Director about the problem.	F 386		
F 387 SS=E	483.40(o)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure that six (6) of nineteen (19) sampled residents were seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Residents #2, #3, #7, #8, #11, and #12 were not seen in according to regulations. Resident #3 had multiple episodes of pneumonia after being last seen by the physician on 07/25/10. Resident #7 was last seen by the physician on 07/25/10 and had sustained multiple falls, restraints implemented and subtherapeutic Dilantin blood levels since the last visit. The findings include: Record review of Resident #2 revealed the	F 387	F387 1. Residents #2, 3, 7,8,11, and 12 will be seen by the attending physician or ARNP by November 18, 2010. 2. An audit of all active Medical Records was completed by Administrator and Health Information Manager on November 4, 8 and 9, 2010. Any resident identified in needing visits will be made and placed in their medical records. 3. The Health Information Manager was re-educated by Administrator on November 9, 2010 on physician visits being made timely and placed in the medical record. Health Information Manager will audit charts monthly for physician visit and meeting with Administrator on finding. Health Information Manager/Administrator will contact attending Physician or ARNP for visits to be made timely via telephone or e-mail. 4. Administrator/ Director of Nursing to monitor five (5) residents' charts to ensure accuracy for specific resident times 2 times weekly times 4 weeks, weekly times 4 weeks and monthly thereafter. Administrator/Director of Nursing Administrator/DNS will report results to the PI committee to ensure compliance times three (3) months.	11/19/2010



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 387	<p>Continued From page 10</p> <p>resident was admitted on 07/01/05 with diagnoses of Delusional Disorder, Anxiety State, Atrial Fibrillation, Hypopotassium, Pain, Constipation, Hemorrhoids, Hearing Loss, Congestive Heart Failure, Diabetes, Hypertension, Cerebrovascular Disease, and Osteoarthritis. The date of the last MD visit for Resident #2 was 07/14/10. Resident #2 had not been seen by a physician for ninety-eight (98) days.</p> <p>Record review of Resident #8 revealed the resident was admitted on 07/17/10 with diagnoses of Epilepsy, Osteoporosis and Other Persistent Mental Disorders. The date of the last MD visit for Resident #8 was 07/25/10. Resident #8 had not been seen by a physician for eighty-seven (87) days. Resident #8 had falls on 08/09/10, 10/07/10 and 10/13/10.</p> <p>Record review of Resident #11 revealed the resident was admitted on 06/09/10 and readmitted on 07/16/10 with diagnoses of Congestive Heart Failure, Hypertension, Atrial Fibrillation, Diabetes, Asthma and Chronic Obstructive Pulmonary Disease. The date of the last MD visit for Resident #11 was 08/20/10. Resident #11 had not been seen by a physician for sixty-two (62) days.</p> <p>Record review of Resident #12 revealed the resident was admitted on 04/07/09 with diagnoses of COPD, Hypopotassium, Obesity, Nausea, Constipation, Asthma, GERD, Asthma, Weakness, Hypertension, Congestive Heart Failure, Kidney Disease, Diabetes, Anxiety, Anemia, Leukosytosis, and Anorexia. The date of the last MD visit for Resident #12 was 07/25/10. Resident #12 had not been seen by a physician</p>	F 387		



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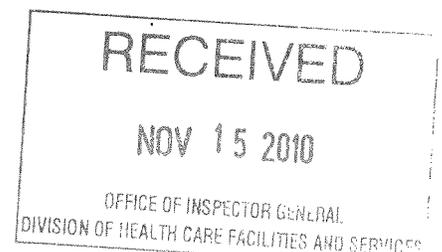
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F 387	<p>Continued From page 11 for eighty-seven (87) days.</p> <p>Review of the clinical record for Resident #3 revealed the resident was admitted with diagnoses of Dysphagia, Gastric Esophageal Reflux Disease, and Seizures. The resident was last seen by the physician on 07/25/10 and documentation indicated the resident had right lower lobe pneumonia and dehydration. The resident was being treated with intravenous fluids and antibiotics. The review of the physician's verbal orders revealed the resident had antibiotics ordered on 08/09/10 for pneumonia, on 08/19/10 for pneumonia, on 09/02/10 for pneumonia, and on 09/13/10 for pneumonia. Chest x-rays completed on 08/09/10, 08/19/10, 09/02/10, and 09/13/10 confirmed the presence of infiltrates in the right lower and middle lobes of the lung. The x-ray completed on 08/19/10 revealed the infiltrates were worse than previous studies. There was no evidence the physician or the Advanced Registered Nurse Practitioner (ARNP) saw the resident during the time period from 07/25/10 until 10/21/10.</p> <p>Review of the clinical record for Resident #7 revealed the resident was last seen by the physician on 07/25/10. Review of the nurses' notes revealed the resident had falls on 09/07/10, 09/20/10, 09/21/10 and 10/02/10. Review of the physician's order for 10/03/10 revealed the resident was to use bilateral bolsters to prevent falls from the bed. Review of the laboratory blood work for 10/15/10 and 10/18/10 revealed the resident had subtherapeutic Dilantin levels. There was no evidence the physician or the ARNP saw the resident during the time period from 07/25/10 until 10/22/10.</p>	F 387			

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F 387	Continued From page 12 Interview with LPN #5 on 10/20/10 at 3:50pm revealed nurses did not monitor physician visits for timeliness. She stated that medical records did the audit. Interview with the Director of Nursing on 10/21/10 at 2:00pm revealed she had not contacted the physician, the facility medical director, and had no reason. Interview with the Health Information Manager on 10/20/10 at 11:25am revealed she created an audit tool tracking related to MD visits monthly and sends it to the MD on a monthly basis. This audit tracks MD visits that need to be made. The monthly audit tool did not track ARNP visits that need to be made. The Health Information Manager revealed that she tracks the audit and if a visit was missed, she noted that on the next month's audit tool that goes to the MD. When asked if she notifies anyone of delinquent visits she revealed that she notified the Director of Nursing and the Administrator. She stated that she did not know what they did with the information. Interview with the Administrator on 10/21/10 at 1:00pm revealed the problem with missed MD visits had been identified and was taken to their PI Committee. When asked if the process was working she revealed it was not. She further stated if there was a specific issue with a resident, the Director of Nursing can call the MD on a personal cell phone. The Administrator revealed that she has spoken to the ARNP about writing progress notes when the ARNP visits residents.	F 387		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465	F465 1. The 4 sitting chairs with armrest detaching and the 1 wooded chair with	11/19/2010



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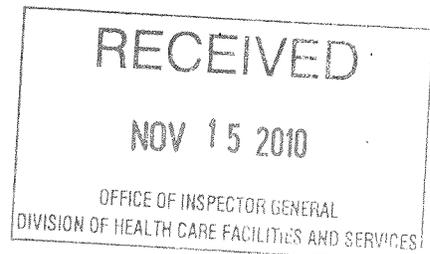
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F 465	<p>Continued From page 13 E ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public related to broken armrests, chair back, and outside loose railing.</p> <p>The findings include:</p> <p>Observation on all three days of the survey in the 200 Joy Room revealed staff, residents and public using four sitting chairs with armrests detaching from the leg piping and one wooded straight back chair with loose legs.</p> <p>An interview with the Housekeeper #2 on 10/21/10 at 9:30am in the 200 Joy Room revealed that she had been off work for several days and Housekeeper #1 had cleaned the 200 Joy Room for the last several days. She further stated that today was the first time she had noticed that one (1) chair armrest was loose and was unaware of the wooded straight back chair being loose. She further stated that she had not filled out a maintenance log for repair of the chair armrest.</p> <p>An interview with the Housekeeper #1 on 10/21/10 at 9:40am revealed that she had been employed since August 2010. She further stated</p>	F 465	<p>loose legs were removed from use on Oct 21, 2010. The 4 sitting chairs were repaired so that the armrests would not detach from the legs on November 4, 2010. The loose handrail on the 200 hallway exit was repaired on October 30, 2010 and is no longer loose. The 1 chair with the loose chair was taken out of use permanently.</p> <ol style="list-style-type: none"> An audit of chairs in the facility was conducted on October 26 and 27, 2010. Any chair found to be in need of repair was repaired or taken out of use. The Administrator/ADNS/DNS will re-educate staff on how to fill out maintenance work orders and any equipment deemed unsafe be removed from use and mark as "Out of Service" to be completed by November 18, 2010. Maintenance work orders are two parts. The white copy will be place in Maintenance request box. A box was placed on the outside of the Administrator door and the yellow copy is to be place in there. Maintenance Director/ Administrator/ DNS will monitor chairs, facility equipment and outside entrances weekly time 4 weeks, 2 times monthly, then monthly thereafter. Maintenance Director/Administrator/ Director of Nursing will report results to the PI committee to ensure compliance times three (3) months. 	

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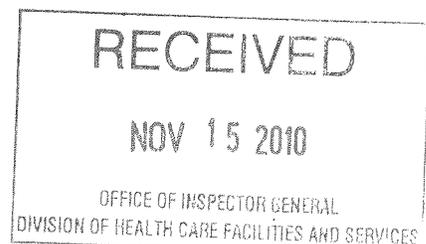
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F 465	<p>Continued From page 14</p> <p>that she has been aware of the detached chair armrest since her employment and that the Assistant Activity Director was aware of the detached chair armrest because she removed one chair from use because both armrests would detach. She further stated that she was unaware the straight back wooded chair had loose legs.</p> <p>An interview with the Assistant Activity Director on 10/21/10 at 9:50am revealed she was made aware of the detached armrests about three (3) weeks ago. She further stated that maintenance was aware of the damaged chairs. She stated that the residents, staff or the public all use the chairs and that the detached armrests could cause injury to a resident, staff or the public. The Assistant Activity Director sat in the straight back chair and stated that the straight back chair legs where loose and wobbly and that it could cause injury to a resident.</p> <p>An interview with Activity Director on 10/21/10 at 9:55am revealed she has had problems with the armrests detaching for over three (3) years and stated that the residents, staff or the public all use the chairs. The Activity Director sat in the straight back chair and stated that the straight back chair legs where loose and wobbled and that could cause an injury. She related that she has never filled out maintenance a log but the Maintenance Director was aware of the problem. She stated she had no system of checking the chairs for damages.</p> <p>An interview with the Maintenance Director on 10/21/10 at 10:30am revealed he was made aware of the detached armrests one (1) week ago in the morning meeting. He further stated he was unsure how to correct the problem with the</p>	F 465		



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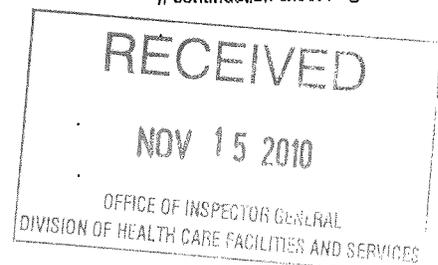
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F 465	Continued From page 15 detached armrests, and that he was unaware of the wobbly straight back chair. He related that he has never received a work order on any of the detached armrests. The Maintenance Director stated that both the straight back loose chair legs and the detached armrests could cause injury. Observation on all three days of the survey revealed that the 200 hallway emergency exit door handrail leading outside was readily movable from side to side with one hand. An interview with Maintenance Director on 10/21/10 at 12:00pm revealed that the 200 exit ramp railing was loose and that it should be secured to prevent injury. He further stated that it needed a brace to prevent movement. Further evidence received by the state agency from the administrator of the facility on 10/28/10 revealed that the 200 hallway emergency exit door hand rail moves slightly from side to side and this was not a safety concern for the residents.	F 465		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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;	F 514	F514 1. Resident # 2,3,6,7,8,9,10,12 and 15 medical records will be complete with missing and signed orders by November 18, 2010. 2. An audit of all active Medical Records was completed by Administrator and Health Information Manager on November 4, 8 and 9, 2010. Any resident identified in needing visits will be made and placed in their medical records. 3. The Health Information Manager was re-educated by the Administrator on	11/19/2010



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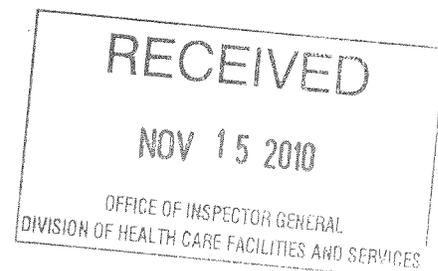
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F 514	<p>Continued From page 16 and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain medical records on nine (9) of thirty-three (33) sampled residents (#2, #3, #6, #7, #8, #9, #10, #12 and #15) in accordance with accepted professional standards. Review of the records revealed the absence of signed and dated physician orders and physician visits.</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #7 revealed signed physician orders for 09/10/10, 09/11/10, 09/13/10, 09/15/10, 09/20/10, 09/21/10, 09/22/10, 09/22/10, 09/23/10, 09/28/10 and 09/30/10 were missing from the record.</p> <p>Review of the clinical record for Resident #3 revealed signed physician orders for 09/02/10 and 09/13/10 were missing from the record. In addition, the signed physician orders for 09/13/10, 08/31/10, and 08/17/10 were not dated when signed.</p> <p>Review of the clinical record for Resident #15 revealed signed physician renewal orders for 08/31/10 were missing from the record and had not been signed.</p> <p>Review of the medical record of Resident #6 on 10/20/10 revealed, physician orders were not signed by the physician on 06/17/10, 06/16/10, and 09/09/10.</p>	F 514	<p>November 9, 2010 on physician visits being made timely and placed in the medical record and on ensuring orders to be dated before placing in medical record and ensuring all orders in medical record. The Health Information Manager will audit charts monthly for physician visits and meet with the Administrator on findings. The Health Information Manager/ Administrator will contact attending Physician or ARNP for visits to be made timely via fax, telephone or e-mail.</p> <p>4. Administrator/ Director of Nursing to monitor five (5) residents' charts to ensure medical records are complete for specific resident times 2 times weekly times 4 weeks, weekly times 4 weeks and monthly thereafter. Administrator/Director of Nursing will report results to the PI committee to ensure compliance times three (3) months.</p>	



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F 514	<p>Continued From page 17</p> <p>Review of the medical record of Resident #9 on 10/20/10 revealed, physician orders were not signed by the physician on 07/19/10 and 08/09/10.</p> <p>Review of the medical record of Resident #10 revealed, physician orders were not signed for 08/24/10, 08/26/10, and 10/14/10.</p> <p>Record review for Resident #2 on 10/19/10 revealed physician orders dated 07/19/10 and 08/07/10 that had not been signed by the MD.</p> <p>Record review for Resident #8 on 10/19/10 revealed physician orders dated 07/17/10, 07/18/10, 07/19/10, 07/26/10, and 08/09/10 which had not been signed by the MD. Monthly physician orders for July and August had not been signed by the MD.</p> <p>Record review for Resident #12 on 10/20/10 revealed physician orders dated 10/04/10 and 10/05/10 that had not been signed by MD.</p> <p>Interview with the Health Information Manager on 10/21/10 at 11:30am revealed the orders were stored in her office and had not been placed on the chart as she has not had the time.</p> <p>Interview with the Director of Nursing on 10/21/10 at 2:00pm revealed she was not aware of orders not being filed. She stated the audit on records revealed no problems.</p>	F 514			



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K 000	INITIAL COMMENTS	K 000		
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that corridors were maintained free from obstructions in the case of fire or other emergencies.</p> <p>The findings include:</p> <p>Observation on 10/20/2010 at 1:30 PM with the Maintenance Director, revealed a wooden bench was blocking the handrail and corridor creating an impediment to the egress. Further observation of the corridors revealed (2) two resident chairs in the corridor next to rooms numbered 204 and 205. The 200 Long Hallway was also observed to have a linen cart and two (2) medication carts. The 200 Short Hallway was observed to have a hoier lift, ice cart, linen cart, two (2) medication carts. The 100 Long Hallway was observed to have a hoier lift, a housekeeping cart, and a</p>	K 072	<p>K072</p> <ol style="list-style-type: none"> 1. Chairs were removed from hallway on November 21, 2010 by Housekeeping supervisor. Linen carts, med carts, hoier lifts and supply carts will be placed to one side of hallway. Ice carts and wheelchairs will be kept out of hallways. Housekeeping carts will be kept out of hallways when not in use. 2. Hallways were checked to see if any other concerns noted related to means of egress by Administrator on November 9, 2010. No other concerns noted. 3. Administrator/Maintenance Director/ Housekeeping Supervisor to make weekly rounds to ensure means of egress clear. Staff will be re-educated by the Housekeeping Supervisor/ Administrator to ensure compliance of means of egress by November 18, 2010. 4. The Maintenance Director/ Housekeeping Supervisor to monitor 3 times weekly times 2 weeks; 2 times weekly times 2 weeks and weekly thereafter to ensure means of egress is clear. Re-education given by Administrator/Maintenance Director/ Housekeeping Supervisor as needed to ensure compliance. Maintenance 	11/19/2010

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

TITLE

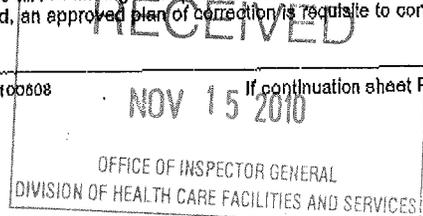
(X6) DATE

X Julie Shinn

Admin's Rep

11/15/10

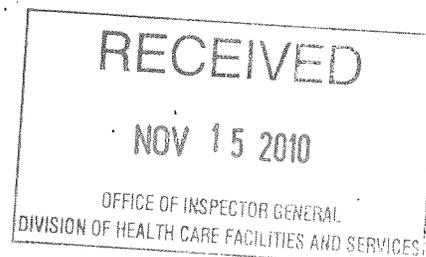
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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: 11/04/2010
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2010
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
K 072	Continued From page 1 wheel chair. The 100 Short Hallway was observed to have four (4) medication carts, a supply cart, a housekeeping cart, and a wheel chair.	K 072	Director/ Housekeeping Supervisor will report results to the PI committee to ensure compliance times three (3) months.	
K 073 SS=F	Interview with the Maintenance Director and Administrator on 10/20/2010 at 3:00 PM, indicted that they would take care of these problems. NFFA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview during the survey on 10/20/2010, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFFA standards. The findings include: Observation during the tour of the building on 10/20/2010 at 10:15 AM, revealed nine (9) resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 108, 111, 112, 120, 205, 206, 208, 210, and 216. Interview with the Maintenance Director on 10/20/2010 at 10:15 AM, indicated that he would spray the decorations with flame retardant and keep record of this information. NFFA Standard NFFA 101.2000 Edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073 K073	1. Hanging decorations on doors of rooms 108,111,112,120,205,206,208,210 and 216 were sprayed with flame retardant on 10/25/10 by Maintenance Director. 2. All other rooms checked to ensure that no other rooms affected. No other concerns noted. 3. The Maintenance Director will make weekly rounds to ensure doors/rooms do not have hanging decorations that have not been sprayed with flame retardant. The Administrator re-educated the Maintenance Director on November 11, 2010 on ensuring compliance of spraying decorations with flame retardant. 4. Maintenance Director/ Administrator will monitor weekly times 4 week and monthly thereafter to ensure decorations are sprayed with flame retardant. Re-education given by Administrator as needed to ensure compliance. Maintenance Director to report results to the PI committee to ensure compliance times three (3) months.	11/19/2010



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2010
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
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical panel boxes had a clear area around them of at least 36 inches.</p> <p>The findings include:</p> <p>Observation on 10/20/2010 at 10:30 AM with the Maintenance Director, revealed the electrical panel box in storage room #3 was blocked by two (2) housekeeping carts. Further observation also revealed the electrical panel box in room #203 was blocked by a two (2) drawer metal cabinet.</p> <p>Interview with the Maintenance Director at 10:30 AM, indicated that the blocked electrical panel boxes would be cleared of the obstructions.</p> <p>Reference: NFPA 70, National Electrical Code. 9.1.2</p>	K 147	<p>K147</p> <ol style="list-style-type: none"> The 2 drawer cabinet was moved on November 21, 2010 to clear 36 inches around electrical panel. Housekeeping carts will no longer block electrical panel. All other rooms checked to ensure electrical panel cleared 36 inches around them. No other concerns noted. The Maintenance Director to make weekly rounds to ensure electrical panels not blocked. The Administrator re-educated Maintenance Director on November 11, 2010 to ensure compliance. The Housekeeping Supervisor/Administrator will also re-educate housekeeping staff on not blocking electrical panels with carts by November 18, 2010. Maintenance Director/Administrator to monitor weekly times 4 weeks and monthly thereafter to ensure electrical panels are not blocked 36 inches around them. Re-education will be given by Administrator/Maintenance Director as needed to ensure compliance. The Maintenance Director/Administrator to report results to the PI committee to ensure compliance times three (3) months. 	11/19/2010

