

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

PRINTED: 01/30/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>FEB 2012</u> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/13/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>OAKVIEW NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10456 US HWY 62 CALVERT CITY, KY 42029</b>
--	--

(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  An abbreviated survey (KY#17148) was conducted on 01/12/12 through 01/13/12. KY #17148 was substantiated with deficiencies cited at the highest S/S of a "D."	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  Resident #1's physician was notified of the change in condition on the day the change was identified and the resident was sent to the hospital for evaluation.  The Director of Nursing and/or Unit Managers will conduct a comprehensive review of current residents and notify families and/or physicians of those residents identified as having a significant change in condition.  The Staff Development Coordinator will inservice the Licensed Nurses on facility policy and procedures related to notification of physicians and families in the event of a significant change in the status of the resident. The Staff Development Coordinator will include information on facility policy and procedures related to notification of physicians and families in the event of a significant change in the status of the resident in the orientation of new Licensed nurses. The Director of Nursing/Unit Manager and Weekend Supervisor will monitor the 24-hour nursing reports on a daily basis to assure physicians and families are notified of significant changes in resident condition.	02/24/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Executive Director</i>	(X6) DATE <i>2/8/2012</i>
---	------------------------------------	------------------------------

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: 01/30/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/13/2012
NAME OF PROVIDER OR SUPPLIER  OAKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029		
(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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to immediately consult with the resident's physician for one resident (#1), in the selected sample of four residents, related to a significant change in the resident's physical, mental, or psychosocial status as evidenced by the failure to notify the resident's physician in a timely manner when he/she displayed uncontrollable "shaking" episodes.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Condition Changes of A Resident," revised 10/31/06, revealed "Resident's change of condition is identified for proper treatment implementation. The physician is informed of resident events and/or change in the resident's condition. Significant change is a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is 'self-limiting.' "</p> <p>A record review revealed Resident #1 was admitted to the facility on 11/22/10 with diagnoses to include Seizures, Parkinson's Disease, Weakness and Dementia.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 08/09/11, revealed Resident #1 was assessed to be cognitively independent and required limited assistance with</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The Director of Nursing or Unit Managers will monitor through resident record and 24 hour report review, at least monthly for three months, then at least quarterly, to assure physicians and families are notified of significant changes in resident status. Findings will be taken to PI monthly times three months or until compliance is achieved. The Administrator is responsible for overall compliance.</p> <p>Completion date is 02/24/12.</p>		

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

PRINTED: 01/30/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>OAKVIEW NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10456 US HWY 62</b> <b>CALVERT CITY, KY 42029</b>	
(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 157	<p>Continued From page 2</p> <p>Activities of Daily Living (ADLs).</p> <p>A review of the nurses' notes, dated 09/13/11 at 10:00 AM, revealed Resident #1 was "very restless in bed, shaking and having to be repositioned frequently." A pain pill was administered to Resident #1 for a complaint of increased pain. Another nurses' note, dated 09/13/11 at 2:45 PM, revealed Resident #1 continued to display some "jerking" movements. The nurses' note revealed an attempt was made to contact the resident's Advanced Registered Nurse Practitioner (ARNP), without success. Another nurses' note, dated 09/13/11 at 4:00 PM, revealed Resident #1 was observed to be shaking, pale in color, and was unable to answer questions after the shaking episode. Resident #1's physician was then notified of the need to transport him/her to the emergency room.</p> <p>An interview with Certified Nurse Aide (CNA) #1 and CNA #2, on 01/13/12 at 3:32 PM and 3:39 PM, respectively, revealed they both provided care for Resident #1 on 09/13/11. CNA #1 stated the resident was "shaking uncontrollably" in episodes which lasted one minute. CNA #2 stated during the episodes of shaking, his/her "eyes rolled in the back of his/her head." CNA #1 and CNA #2 stated that they both notified the nurse, and later notified the Unit Manager, because the shaking did not subside.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/13/12 at 4:44 PM, revealed on 09/13/11, the resident was "shakier" than usual. She stated she did not document the "shaking" in the nurses' notes, if it was normal for the resident. She stated the increase in shaking was</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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

PRINTED: 01/30/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/13/2012
NAME OF PROVIDER OR SUPPLIER  OAKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029		
(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 157	<p>Continued From page 3</p> <p>considered to be a change in condition; however, she wanted to determine whether the pain pill was effective or not, because the resident did have occasional pain.</p> <p>An interview with LPN #2, on 01/13/12 at 2:28 PM, and Registered Nurse (RN) #1, on 01/13/12 at 5:20 PM, revealed they considered "shaking" a change in condition and would have notified the physician immediately.</p> <p>An interview with the Director of Nursing (DON), on 01/13/12 at 5:39 PM, revealed she was notified by a nurse, on 09/13/11, that Resident #1 was "not acting like" himself/herself. Resident #1's physician was notified and he/she was sent out to the hospital for an evaluation. She stated she expected the staff to assess the resident if he/she displayed a substantial change in condition, and to contact the physician based on that assessment.</p> <p>An interview with the ARNP, on 01/13/12 at 5:50 PM, revealed she expected the staff to notify her of any changes in a resident. She stated "I would rather know than not know."</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		