

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

PRINTED: 04/03/2013
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 03/21/2013
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 from 03/19/13 through 03/21/13 and a Life Safety Code survey was conducted on 03/21/13. 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 survey was conducted on 03/19/13 through 03/21/13 to investigate KY19890. The Division of Health Care unsubstantiated the allegation.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owenton Manor Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure resident dignity by placing one (1) of eighteen (18) sampled residents (Resident #14) at a dining table appropriate for him/her to eat in a normal eating position. The findings include: Observations, on 03/19/13 at 12:25 PM, revealed Resident #14 in the dining room for lunch sitting at a dining table that was higher than her chin. He/she was sitting in a low wheelchair that	F 241	1. Resident # 14 was provided with an appropriate table height of 26" to accommodate her needs on 04/12/13 by the Director of Nursing. 2. The Director of Nursing and Administrator observed center dining room areas to determine residents are sitting at an appropriate table height on 04/12/13. As a result, one resident was provided with an alternative table that better meets their needs. 3. Clinical staff will be re-educated on seating residents at tables that will allow a normal eating position by the Director of Nursing as of 04/29/13. Admissions to the center will be observed while seated at dining tables to validate they have normal eating positions as they	

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

TITLE

(X6) DATE

[Signature]

Administrator

4/2-13

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.

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

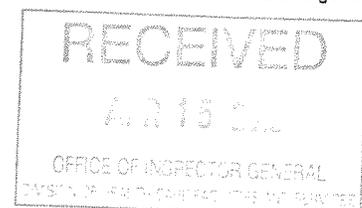
PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

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 03/21/2013
--	--	--	--

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 241	<p>Continued From page 1</p> <p>caused him/her to have to raise his/her arms above the table and Resident #14 used his/her right hand to obtain food from his/her plate and put it in his/her mouth with his/her hand. There were pie crumbs on the table and Resident #14 licked the crumbs with his/her tongue. On each side of Resident #14 were sitting two (2) Certified Nursing Assistant (CNA) students. Standing close to the table was the CNA Instructor.</p> <p>Interview with the two (2) student CNAs, on 03/20/13 at 11:00 AM, revealed they saw Resident #14 eat with his/her fingers and lick the table top; however did not intervene, they stated the table was too high for the resident.</p> <p>Observations, on 03/19/13 at 5:30 PM, revealed Resident #14 sitting at different table in the dining room. The table was lower than the table the resident was sitting at during lunch.</p> <p>Review of the clinical record revealed the facility admitted Resident #14 on 07/26/11 with diagnoses of Dementia, Cerebral Vascular Accident, Dysphagia, and Alzheimers.</p> <p>Interview with a Physical Therapy Department (PT) worker, on 03/19/13 at 5:30 PM, revealed the resident was in a low wheelchair for body alignment. She stated she was not aware the resident could not see his/her plate.</p> <p>Interview with the Director of PT, on 03/20/13 at 9:00 AM, revealed when the dining table was measured for Resident #14 to eat in a normal dining position the table needed to be less than twenty-eight (28) inches high. She further stated, the resident had been in a low wheelchair since</p>	F 241	<p>occur and residents accommodated with appropriate table height as necessary.</p> <p>4. The Administrator and/or Director of Nursing will observe resident meals daily (Monday through Friday) to determine residents are seated at appropriate tables for normal eating positions. These observations will be discussed at the monthly performance improvement committee meetings for review and further recommendations.</p> <p>Compliance date: April 30, 2013</p>	
-------	---	-------	---	--



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

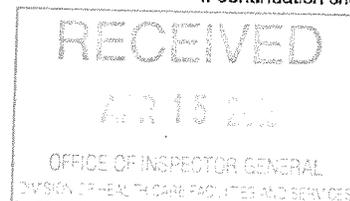
PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

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 03/21/2013
--	--	--	--

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 241	Continued From page 2 July of 2012. The table the resident was sitting at, on 03/19/13 at 12:30 PM, was thirty-three and one-half (33.5) inches high. The table the resident was sitting at, on 03/19/13 at 5:30 PM, was twenty-nine and one-quarter (29 1/4) inches high. The PT Director measured the height of Resident #14 in relationship to a normal eating position revealed the correct table height should be approximately twenty-seven (27) inches high.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and Interviews, It was determined the facility failed to provide for one (1) of eighteen (18) sampled residents (Resident #14) a dining table at the appropriate height for the resident to eat in a normal eating position. The findings include: Observations, on 03/19/13 at 12:30 PM, revealed Resident #14 was seated at a dining table that	F 246	1. Resident # 14 was provided with an appropriate table height of 26" to accommodate her needs on 04/12/13 by the Director of Nursing. . 2. The Director of Nursing and Administrator observed center dining room areas to determine residents are sitting at an appropriate table height on 04/12/13. As a result, one resident was provided with an alternative table that better meets their needs. 3. Clinical staff will be re-educated on seating residents at tables that will allow a normal eating position by the Director of Nursing as of 04/29/13. Admissions to the center will be observed while seated at dining tables to validate they have normal eating positions as they	



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

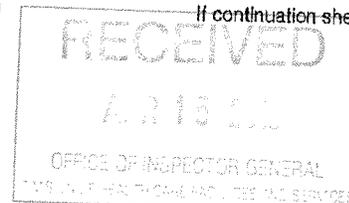
PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

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 03/21/2013
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

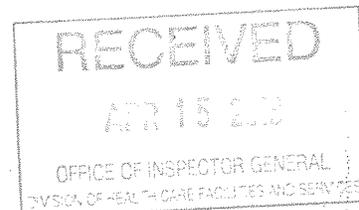
F 246	Continued From page 3 was 32 1/2 inches high. He/she could not see his/her plate and had to raise his/her right arm at head level to eat with his/her hands. On 03/19/13 at 5:30 PM, Resident #14 was seated at the 29 and 1/4 inch table in the dining room. He/she could see across the plate, but still had to raise his/her arms to reach the food. Resident #14 utilized a low wheelchair for body alignment initiated by the Physical Therapy Department in July 2012. Observations, on 03/20/13 at 9:00 AM, of the dining tables revealed all the dining room tables were thirty-two and one-half (32 1/2) inches or twenty-nine and one-quarter inches high (29 1/4). Observations on 03/19/13 at 12:25 PM, revealed Resident #14 was licking the dining table to eat pie crumbs and using his/her hands to bring food from his/her plate to his/her mouth due to not being able to see the entire food service, and had to raise his/her arms above the head to utilize a knife or fork. Interview with the Physical Therapy Department Director, on 03/20/13 at 9:00 AM, revealed the facility had purchased new dining tables, but had not assessed residents to identify if special tables were needed. The new adjustable tables measures 29 1/2 inches in height. She stated after measuring the the tables, the resident should have been eating at a table approximately twenty-seven (27) inches high. This would allow the resident to properly see and cut his/her food, reaching down to bring food to his/her mouth. Observations of the Activity Department tables, on 03/19/13, revealed a table that was the correct height for Resident #14. However, the Activity	F 246	occur and residents accommodated with appropriate table height as necessary. 4. The Administrator and/or Director of Nursing will observe resident meals daily (Monday through Friday) to determine residents are seated at appropriate tables for normal eating positions. These observations will be discussed at the monthly performance improvement committee meetings for review and further recommendations. Compliance date: April 30, 2013	
-------	---	-------	--	--



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

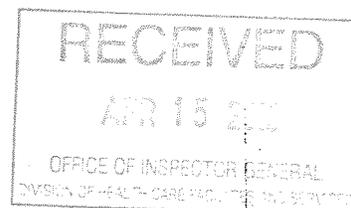
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 246	Continued From page 4 Director stated this table was not to be used for resident dining. Observations on 03/19/13, 03/20/13 and 03/21/13 revealed no residents were using the puzzle table during meals. At meal times the tables in the activity room were used for dining by residents except the puzzle table.	F 246			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to maintain the facility in a clean and homelike manner in six (6) of fifty-one (51) rooms, one (1) of two (2) shower rooms and two (2) of two (2) common areas. The findings include: The facility did not provide a policy regarding maintenance of the facility. Observation during tour, on 03/19/13 at 9:30 AM, revealed two (2) resident bathrooms (Rooms 116 and 119) had no working light in the bathroom, four (4) resident bathrooms (Rooms 103, 105, 117 and 123) commodes had caulking around the commodes that were stained dark brown and one (1) shower room (100 hall) had a sink that was pulling away from the wall and the faucet was leaking. In addition, the common outdoor area for residents had a trash can that was	F 253	1. The lights were replaced in resident bathrooms 116 and 119 on 03/21/13 by the Maintenance Director. The caulking on the commodes in rooms 103, 105, 117 and 123 was replaced on 03/21/13 by the Maintenance Director. The shower room (100 Hall) sink and faucet were repaired on 03/21/13 by the Maintenance Director. The courtyard (common outdoor area for residents) was cleaned, broken items discarded, and landscaped, including removal of cigarette butts on 04/10/13 by the Maintenance Director. The front entrance area, including center parking lot was cleaned and trash discarded, including cigarette butts on 4/11/13 by the Housekeeping Manager and Maintenance Director. 2. The Administrator, Maintenance Director and Housekeeping Supervisor		



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

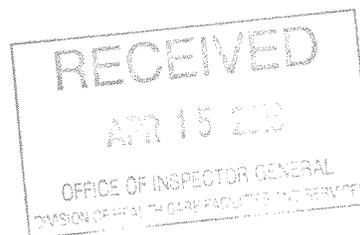
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 253	<p>Continued From page 5</p> <p>overflowing, broken flower bed fencing around the flower beds, broken fencing around the air conditioner, the flower beds and flower pots were unkept, a paint roller handle was lying on the ground and thousands of cigarette butts were found on the concrete slab and flower beds. Continued observations of the grounds revealed the area around the front entrance of the facility had thousands of cigarette butts in the mulch by the front door and out in the parking lot. There was trash noted to be around the bushes in the front of the facility.</p> <p>Interview with the Maintenance Director, on 03/20/13 at 4:15 PM, revealed he had a system to keep up with routine maintenance needs. He stated he also depended on staff to complete a maintenance request and place the request on his door. He checked that every day and completed the needed repairs identified. He stated he did not keep any type of record or log of the work he had completed. He stated the outside common area of the facility are not homelike and they needed to be cleaned up. He did not have an explanation as to why they ere so unkept.</p> <p>Interview with the Director of Nursing, on 03/21/13 at 11:00 AM, revealed some education had been done with the staff about how to fill out maintenance request forms and during Resident Council meetings, the residents were encouraged to report any maintenance needs. She stated the system had broken down because the staff had not been reporting maintenance needs.</p> <p>Interview with the Administrator, on 03/21/13 at 11:15 AM, revealed she was aware of some the</p>	F 253	<p>completed center rounds on 4/11/13 to further identify any areas of opportunity to improve the environment for residents. Areas identified for improvement will be completed as of 4/29/13 by the Maintenance Director and/or Housekeeping staff.</p> <p>3. Center staff nursing and non-nursing including Housekeeping staff and the Maintenance staff were re-educated by the Administrator and/or Director of Nursing on maintaining a clean, comfortable and homelike environment for the residents as of 4/29/13. Re-education will include that it is the responsibility of every discipline to maintain a homelike environment and that specific maintenance or housekeeping needs should be requested timely, including the completion of Maintenance Request Forms.</p> <p>4. The Administrator and/or Director of Admissions will conduct twice weekly environmental rounds and report findings to the Maintenance Director and/or Housekeeping Supervisor for correction. Results of environmental rounds will be brought to the Performance Improvement Committee meetings by the Administrator monthly for further review and recommendation.</p> <p>Compliance date: April 30, 2013</p>		



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

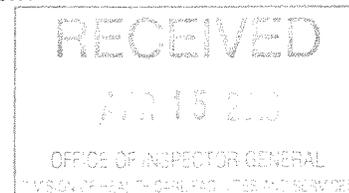
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 253	Continued From page 6 concerns identified. She stated in the past, routine maintenance was not always completed and when staff requested work to be done, it was not completed. The common areas should have been cleaned up. She stated there had been an attitude of indifference by the staff and that was part of the problem. She stated she and a nurse consultant were doing weekly environmental rounds to identify needs and reported those needs to the Maintenance Director.	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to follow the comprehensive plan of care for one (1) of the eighteen (18) sampled residents (Resident #7). The facility failed to release Resident #7's self releasing seat belt during the meal service. The findings include: Review of the facility's policy regarding Care Plans, revised 05/01/11, revealed a comprehensive care plan's purpose was to provide the necessary care and services to attain or maintain the patient's highest practicable	F 282	1. The self releasing seat belt alarm for resident # 7 was discontinued by the physician on 4/7/13. CNA #1 will be re-educated by the Director of Nursing as of 4/29/13 on the center's restrictive device management program and following the nurse aide care card. 2. Center residents who use a restrictive device will be reviewed by the IDT to determine it is clinically appropriate for the resident(s), care plans and nurse aide care cards are current, and that physicians orders are being followed regarding check and release of the restrictive device as of 4/29/13. Resident care plans and care cards of current residents will be reviewed by the IDT as of 4/29/13 to determine they are reflective of residents' needs. Any issues will be corrected at that time.	



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

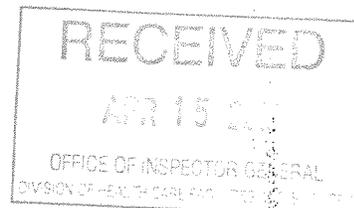
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 282	<p>Continued From page 7 physical, mental, and psychosocial well being.</p> <p>Review of th clinical record revealed the facility admitted Resident #7 on 12/12/11, with diagnoses of Anxiety and Dementia. The facility assessed the resident utilizing a Quarterly Minimum Data Set (MDS), dated 02/15/13, as having severe cognitive impairment with a brief interview of mental status (BIMS) score of 3. The facility assessed the resident as having fluctuations in disorganized thinking, required extensive assistance with ambulation, the resident had sustained a fall since the prior assessment, and utilized a self-releasing seat belt daily. Review of the facility's device evaluation, dated 09/20/12, revealed Resident #7 had a decreased awareness of safety needs and required a self releasing seat belt to maintain positioning in the wheelchair and alert the staff of unsafe attempts to transfer.</p> <p>Review of Resident #7's comprehensive plan of care revealed the facility had identified a risk for falls and determined a goal to have no significant injury related to a fall. The facility initiated the intervention of a self releasing seat belt to alert staff of unsafe attempts to self transfer. Continued Review of the care plan revealed staff were to check the resident every 30 minutes, release the seat belt every two (2) hour. In addition, the care plan revealed the facility staff was to remove the seat belt at meals and during the activities of daily living.</p> <p>Observation of the lunch meal service in the 100 Joy dining room, on 03/19/13 at 12:36 PM, revealed the resident was sitting in a wheelchair eating lunch with the seatbelt attached and</p>	F 282	<p>3. Nursing clinical staff will be re-educated by the Director of Nursing by 4/29/13 on following care plans and care cards including to release any restrictive device during care and at meal times.</p> <p>4. The Director of Nursing and/or Administrator will complete center rounds during meal times and activities daily Monday through Friday to validate restrictive devices are being released per physician order and plan of care. The Director of Nursing and/or Nursing Supervisors will audit five resident care plans/care cards per week to determine they continue to be current and reflective of care needs. The Director of Nursing will review results of the care plan/care card audits with the performance improvement committee monthly for further review and recommendation. (Center IDT: Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Social Services Director, Nutritional Services Director, Therapy Program Manager)</p> <p>Compliance date: April 30, 2013</p>	



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

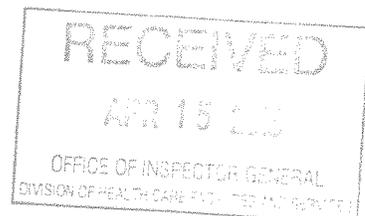
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, 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 282	<p>Continued From page 8 loosely fastened around the resident.</p> <p>Observation of the evening meal service in the 100 Joy dining room, on 03/19/13 at 6:30 PM, revealed the resident was sitting in a wheelchair eating dinner with the seatbelt loosely fastened around the resident's waist.</p> <p>Observation of the lunch meal service in the 100 Joy dining room, 03/20/13 at 12:20 PM, revealed a CNA student was setting up Resident #7's meal tray while being directed by CNA #1. Another CNA student then sat and talked with the resident while he/she ate his/her meal with the self releasing seat belt fastened around the resident.</p> <p>Interview with CNA #1, on 03/20/13 at 12:30 PM, revealed she was not aware the seatbelt was to be removed during meals and revealed they had not received training on the application and usage of seatbelts. The CNA revealed there was a facility CNA care plan that the nurses filled out, but revealed it stayed at the desk and they did not carry a copy of the care plan with them to refer too. The CNA revealed she did not know if information regarding the seatbelt application was on the CNA care plan.</p> <p>Review of Certified Nursing Assistant (CNA) care plan revealed checks and times to release the seatbelt was not included on the CNA plan of care.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/20/13 at 12:33 PM, revealed the CNA's had received in-services regarding seatbelts and should have released the seatbelt during Resident #7's meal as per the facility care plan.</p>	F 282		



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

PRINTED: 04/03/2013
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 03/21/2013
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)	(X6) COMPLETION DATE	
F 282	<p>Continued From page 9</p> <p>The LPN revealed use of a seatbelt, and when to release, should be listed on the CNA care plan but she had not checked to see if the information was listed and communicated to the CNA's.</p> <p>Interview with the 100 Unit Manager, on 03/20/13 at 12:50 PM, revealed the CNA care plans should list when the seat belt should be released. The Unit Manager revealed she was responsible to ensure the CNA care plans were updated. The Unit Manager revealed nurses should be in the dining area during the meals to monitor and ensure any restraints or seatbelts were removed. The Unit Manager revealed a facility nurse was not present during the meal service on 03/19/13 or on 03/20/13. The Unit Manager revealed she was not monitoring to ensure seatbelts were being removed as care planned.</p> <p>Interview with the Asslstant Director of Nursing (ADON), on 03/20/13 at 2:10 PM, revealed she had not provided the facility with education or in-services on the use of seatbelts regarding when to apply and when to remove.</p> <p>Interview with the Director of Nursing (DON), on 03/20/13 at 2:20 PM, revealed she thought restraint usage, which covered the use of seatbelts, was on the required computer education modules.</p> <p>Review of the modules revealed there was no education on seat belts.</p> <p>Continued interview with the DON revealed the CNA care plans were redesigned a month ago and she did not monitor or review the forms to ensure they were correct or included all of the</p>	F 282			



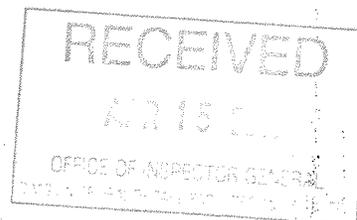
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2013
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 03/21/2013
--	--	--	--

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

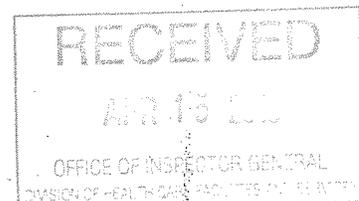
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10	F 282		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow the physician orders for one (1) of the eighteen (18) sampled residents (Resident #7) regarding the removal of a self releasing seat belt during resident meals.</p> <p>The findings include:</p> <p>Review of the clinical record revealed the facility admitted resident #7 on 12/12/11, with diagnoses of Anxiety and Dementia. The facility assessed the resident utilizing a Quarterly Minimum Data Set (MDS), dated 02/15/13, as having severe cognitive impairment with a brief interview of mental status (BIMS) score of 3. The facility assessed the resident as having fluctuations in disorganized thinking, required extensive assistance with ambulation, the resident</p>	F 309	<p>1. The self releasing seat belt alarm for resident # 7 was discontinued by the physician on 4/7/13. CNA #1 will be re-educated by the Director of Nursing as of 4/29/13 on the center's restrictive device management program and following the nurse aide care card. The 100 Unit Manager is no longer working at the center as of 3/27/13.</p> <p>2. Center residents that have a seat belt alarm will be reviewed by the IDT to be sure it is clinically appropriate for the resident(s) and that physicians orders are being followed to check and release the seat belt if indicated.</p>	



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

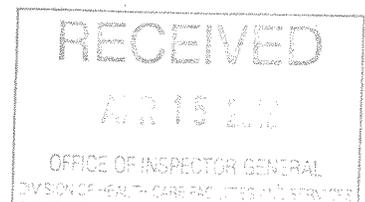
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 309	<p>Continued From page 11</p> <p>sustained a fall since the prior assessment, and utilized a seat belt daily. Review of the facility's device evaluation, dated 09/20/12, revealed Resident #7 had a decreased awareness of safety needs and required a self releasing seat belt to assist with positioning in the wheel chair and to alert the staff of unsafe attempts to transfer. Review of the physician orders revealed an order, initiated on 12/19/12, for a self releasing seat belt to the resident's wheelchair to alert the staff of unsafe attempts to self transfer. The physician orders directed the facility staff to complete routine checks every 30 minutes and release the seatbelt every 2 hours due to the resident's history of falls. In addition, the physician orders revealed the seatbelt was to be removed for meals and activities of daily living.</p> <p>Observation of the lunch meal service in the 100 Joy dining room, on 03/19/13 at 12:36 PM, revealed the resident sitting in a wheelchair eating his/her lunch with the seatbelt attached and loosely fastened around the resident.</p> <p>Observation of the evening meal service in the 100 Joy dining room, on 03/19/13 at 6:30 PM, revealed the resident was sitting in a wheelchair, eating his/her dinner with the seatbelt loosely fastened around the resident's waist.</p> <p>Observation of the lunch meal service in the 100 Joy dining room, 03/20/13 at 12:20 PM, revealed a Certified Nursing Assistant (CNA) student was setting up Resident #7's meal tray while being directed by CNA #1. A CNA student then sat and talked with the resident while the resident ate his/her meal with the self releasing seat belt still fastened around the resident's waist.</p>	F 309	<p>3. Nursing clinical staff will be re-educated by the Director of Nursing by 4/29/13 on center's restrictive device management program, including to release any restrictive device during care and at meal times.</p> <p>4. The Director of Nursing and/or Administrator will complete center rounds during meal times and activities daily Monday through Friday to validate restrictive devices are being released per physician order and plan of care. The Director of Nursing and/or Administrator will review results of rounds monthly with the performance improvement committee for further review and recommendation. (Center IDT: Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, Social Services Director, Nutritional Services Director, Therapy Program Manager)</p> <p>Compliance date: April 30, 2013</p>	



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

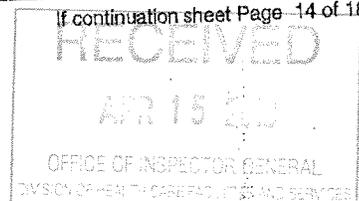
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 309	Continued From page 12 Interview with CNA #1, on 03/20/13 at 12:30 PM, revealed she was not aware the self releasing seat belt was to be removed during the meal service. The CNA revealed she has not received training on seatbelts. The CNA revealed each resident had a CNA care plan at the desk. However, the CNA revealed she did not keep a copy with her. Review of the CNA care plan did not list the physician ordered checks or the release times. Interview with the 100 Unit Manager, on 03/20/13 at 12:50 PM, revealed the CNA care plans should list when the seat belt was to be removed. The Unit Manager revealed she was responsible to ensure the CNA followed the physician orders. The Unit Manager revealed nurses should be in the dining area during meals to monitor and ensure all seatbelts were removed. However, the Unit Manager revealed a facility nurse was not present during the meal service on 03/19/13, or on 03/20/13. The Unit Manager revealed she was not monitoring to ensure seatbelts were being removed as ordered by the physician. Interview with the Assistant Director of Nursing (ADON), on 03/20/13 at 2:10 PM, revealed she did not provide education or in-services on the use of seatbelts. Interview with the Director of Nursing (DON), on 03/20/13 at 2:20 PM, revealed she monitored to ensure seatbelts were being released while performing monthly chart reviews by reviewing the treatment administration record (TAR) to see if the intervention for safety checks and removal	F 309		



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

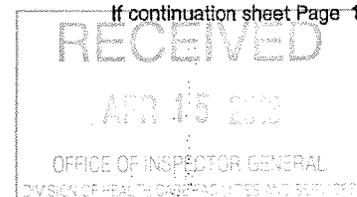
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 309	Continued From page 13 had been initialed as completed. The DON revealed the TAR included orders pertinent to seatbelts, which would indicate the task was completed as ordered by the physician. Review of the TAR revealed it was initialed as completed, on 03/19/13, for the day and evening shift as having released the seatbelt as ordered by the physician. Interview with the 100 Unit Manager, on 03/20/13 at 2:40 PM, revealed she was Resident #7's assigned nurse for 03/19/13 and did sign off the TAR for removing the self releasing seat belt as ordered by the physician. However, the Unit Manager revealed she did not actually monitor to ensure the seatbelt was removed as ordered by the physician.	F 309		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to dispose of garbage properly. Two (2) of two (2) dumpsters were overfilled and the lids were left open. The findings include: Observation, on 03/20/13 at 4:15 PM, revealed two dumpsters located in the rear of the building were both filled with trash bags over the upper level of the container and the lids were open.	F 372	1. The over-filled dumpsters were emptied by the waste collection service on 3/21/13. The dumpster lids were then secured appropriately by the Maintenance Director on 3/21/13. 2. The Administrator, Maintenance Director, Housekeeping Director and/or Nutritional Services Director observed the center dumpster containers on 3/22/13,	



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

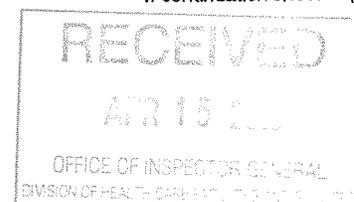
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 372	Continued From page 14 Interview with the Maintenance Director, on 03/20/13 at 4:15 PM, revealed he tried to close the lids but was unable to due to the dumpsters being so full. He stated the dumpsters are supposed to be emptied by the waste company two times a week. He stated the concern with leaving the dumpster doors open and uncovered was that it would attract rodents which could then get in the building. Interview with the Administrator, on 03/21/13 at 11:15 AM, revealed the dumpsters had been identified as an area of concern in the past. She stated she was very upset to know the dumpsters had been left open due to the quality focus the facility had been doing on that issue.	F 372	3/25/13, 3/26/13 and 3/27/13 to validate they were secured appropriately. Any issues were immediately addressed at that time. 3. The Administrator will contact the waste collection provider by 4/29/13 to discuss the frequency of service based on center need. Center staff, nursing and non-nursing, will be re-educated by the Maintenance Director and/or Administrator on the proper disposal of trash in the dumpsters and the importance of ensuring the dumpsters are closed and secure by 4/29/13. 4. The Administrator and/or Maintenance Director will audit the center dumpster containers daily (Mon-Fri) to validate trash is contained as appropriate. Any concerns will be corrected immediately. Results of the daily audit will be discussed by the Performance Improvement Committee monthly for further review and recommendation. Compliance date: April 30, 2013		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	1. The six D5 normal saline IV solution, one Vancomycin antibiotic, one Ativan and three Tetanus solutions were removed from the medication room by the licensed nurse on 03/21/13.		



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

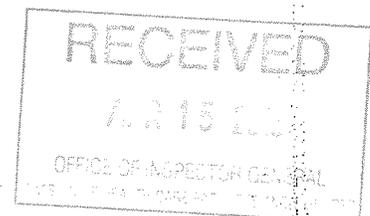
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 431	<p>Continued From page 15</p> <p>locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to dispose of expired medications in a timely manner. Six (6) of six (6) D5 Normal Saline (NS) Intravenous solution (IV), one (1) of one (1) Vancomycin antibiotic, one (1) of one (1) vials of Ativan and three (3) of three (3) Tetanus Toxoid Solutions were found to be expired.</p> <p>The findings include:</p> <p>Review of the facility's Pharmacy Services and Procedures Manual, effective 12/01/07, revealed the facility staff should destroy and dispose of medications in accordance with facility policy and applicable law. The facility should place all discontinued or out-dated medications in a designated, secure location which was solely for discontinued medications or marked to identify the medications are discontinued and subject to</p>	F 431	<p>2. The Director of Nursing and/or Nursing Supervisor will review the medication rooms, medication carts, and refrigerators storing medications as of 4/29/13 to determine there are no expired medications. Any issues will be immediately addressed and medications removed from storage at that time. In addition, the pharmacy consultant will review medication storage to further validate there are no expired medications as of 4/29/13.</p> <p>3. Center licensed nurses and medication aides will be re-educated by the Director of Nursing on the center's pharmacy services policy regarding storage of medications as of 4/29/13. The licensed nurse will review medication rooms, medication carts and refrigerators daily (Monday through Friday) that store medication to determine discontinued medications and/or expired medications have been removed and discarded.</p> <p>4. The Director of Nursing and/or Nursing Supervisors will review medication rooms, medication carts and refrigerators that store medication weekly to validate no expired medications are being stored. The Director of Nursing will discuss the results of these reviews monthly with the performance improvement committee for further review and recommendations.</p> <p>Compliance date: April 30, 2013</p>	



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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

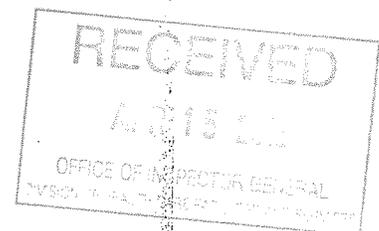
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 431	<p>Continued From page 16 destruction.</p> <p>Observation of the Medication room on the 200 hall, on 03/20/13 at 9:40 AM, revealed six (6) of six (6) D5 NS, IV solutions, with expiration dates of 03/11/13, were stored in a cupboard that was accessible to staff.</p> <p>Observation of the Secured Refrigerator, on 02/20/13 at 9:40 AM, revealed a Vancomycin vial with an expiration date of 03/11/13, an Ativan vial expired 02/2013 and three (3) Tetanus Toxoid vials that had expired on 02/28/13. All of these items were stored in a manner that left them accessible to the nursing staff for use on the residents.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 03/21/13 at 11:31 PM, revealed Nurses were responsible for removing expired medications from the refrigerator. LPN #2 stated she did not think anyone was assigned to complete the task of removing expired medications. LPN #2 stated she was not aware if it was a night shift duty. LPN #2 stated expired medications were removed to ensure residents were not given the medication. If an expired medication was given to a resident an adverse reaction could occur.</p> <p>Interview with the 200 hall Unit Manager, on 03/20/13 at 9:50 AM, revealed pharmacy staff came in once a week to remove expired medications. The Unit Manager further stated the stock person removed the expired stock items.</p> <p>Interview with the 200 hall Unit Manager, on 03/20/13 at 9:50 AM; revealed nurses were responsible for removing expired medications.</p>	F 431			



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

PRINTED: 04/03/2013
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 03/21/2013
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 431	<p>Continued From page 17</p> <p>The Unit Manager stated IV fluids could be removed and placed in the pharmacy bin. The Unit Manager stated as the Unit Manager she was responsible for knowing the process involving the expired medications. The Unit Manager stated there was no process for the removal of expired medications and if a resident was to take an expired medication an adverse reaction could occur.</p> <p>Interview with the Director of Nursing (DON), on 03/21/13 12:53 PM, revealed once a medication was discontinued the nurse was to remove and place the medication in a tote. The DON stated the Unit Manager was fairly new and if she needed any help, there was someone available to assist her. The DON stated she tried to go to the medication room weekly, however she had not been in the medication room for a couple of weeks. The DON stated they did not want to give expired medications to residents because it may harm them or they may have a reaction.</p>	F 431		



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

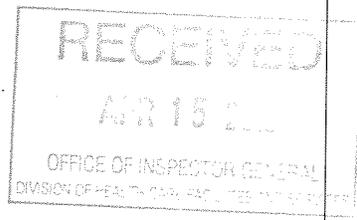
PRINTED: 04/02/2013
FORM APPROVED
OMB NO. 0938-0391

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 03/21/2013
--	--	--	--

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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1977</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system</p> <p>GENERATOR: Type II generator installed in 1991. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/21/13. Owenton Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid in accordance with title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire.) The facility is licensed for one hundred (100) beds with a census of eighty seven (87) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
-------	--	-------	--	--



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *4-12-13*

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.

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

PRINTED: 04/02/2013
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 03/21/2013
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 000	Continued From page 1 Fire).	K 000		
K 069 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. NFFA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFFA 96 This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure kitchen hood systems were inspected according to National Fire Protection Association (NFFA) standards. The deficiency had the potential to affect one (1) smoke compartment. The findings include: Observation on 03/21/2013 at 11:10 AM, with the Maintenance Director revealed the facility failed to perform semi-annual hood cleaning of the hood located in the Kitchen. Review of the semi-annual kitchen hood system inspection records on 03/21/2013 at 11:22 AM, revealed the last documented cleaning was 04/25/2012. Interview on 03/21/2013 at 11:22 AM, with the Maintenance Director revealed he was not aware that the last semi annual kitchen hood system had not been performed.	K 069	1. The kitchen hood system was inspected and cleaned on 03/21/13 by Fesco/Fassco contractor and found to be in working order. 2. The Maintenance Director re-established a semi-annual cleaning and inspection schedule with the vendor. The Maintenance Director added this schedule to the center's automated Preventative Maintenance System, TELS, to provide the center with notices when upcoming hood inspection is due to be completed. 3. The Maintenance Director was re-educated by the Administrator on the requirement of kitchen hood inspections according to NFFA Standards on 4/12/13. 4. The Maintenance Director and Administrator will review the Preventative Maintenance (PM) TELS report to determine all PM has been completed, including the kitchen hood inspection each month. The PM TELS report will also be brought to the Performance Improvement Committee meeting monthly for further review and recommendation. 5. Compliance date: April 30, 2013	

