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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING B. WING	C 07/01/2011

RECEIVED JUL 2011 OFFICE OF INSPECTOR GENERAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON HARBOR NSG & REHAB CENTER	2420 W. 3RD ST. OWENSBORO, KY 42301

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F 000	INITIAL COMMENTS Abbreviated surveys (KY #15801 and KY #16471) were conducted on 06/29/11 through 07/01/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of "D." KY #16471 was substantiated with deficiencies cited. KY #15801 was unsubstantiated with unrelated deficiencies cited.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the Plan of Correction within this timeframe should in no way be construed or considered as an agreement with	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide a clean, comfortable and homelike environment. On 06/29/11 through 07/01/11, observations of the 400 Hall and Room #451 revealed a strong urine odor was present. Findings include: Observations of the 400 Hall, on 06/29/11 at 10:10 AM, on 06/30/11 at 6:00 PM and on 07/01/11 at 7:10 AM and 9:45 AM, revealed a strong urine odor was present throughout most of the area. Additionally, an observation of Room #451 revealed a strong urine odor was present	F 252		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna Davis	Administrator	7/27/11

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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F 252	Continued From page 1 and there were multiple flies observed on the bed and flying around the room. An interview with Housekeeping Staff # 1, on 06/30/11 at 9:45 AM, revealed she was aware of the urine odor that was present on the 400 Hall and Room #451, because this was her usual assignment. She revealed she was supposed to clean Room #451 two times daily due to the urine odor. She stated urine was usually everywhere in Room #451 and the tiles on the floor contained an odor that could not be cleaned off. An interview with the Housekeeping Supervisor, on 06/30/11 at 10:00 AM, revealed he was aware of the urine odor on the 400 Hall and stated the housekeeping staff were supposed to use an odor neutralizer. He was not aware of any instructions for cleaning Room #451 two times a day and he usually did a tour of the facility weekly. No further explanation was provided for the strong urine odor present on the 400 Hall and Room #451.	F 252	the allegations of noncompliance or admissions by the facility. F252 1. The 400 hall has been deep cleaned and no urine odor is present. Room #451 has been deep cleaned and no urine odor is present. 2. All other halls and roomed have been assessed by the administrator and the housekeeping services manager and no lingering urine odors were noted. 3. All staff have been retrained on checking for odors in target rooms and on the timely cleaning of floors and areas where residents have been incontinent. No staff will work after 8/2/11 without receiving this education.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide services to meet professional standards of quality for one resident (#3), in the selected sample of three, related to a resident who received medication that was discontinued by the physician.	F 281	4. The Administrator and/or the Housekeeping services manager will check all rooms five days per week times two weeks and weekly thereafter to ensure there no odors present. The results of these room checks will be presented to the center Quality Assurance team monthly for three months for review and recommendations.	8/3/11

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F 281	Continued From page 2 Findings include: A record review revealed Resident #3 was admitted to the facility on 05/02/05 with diagnoses to include Non-Insulin Dependent Diabetes Mellitus (NIDDM), Left Cerebral Vascular Accident (CVA) with right upper extremity paresis, Urinary Retention, Depression and Alzheimer's Disease. Further record review revealed the pharmacy made a recommendation, on 05/05/11, for Remeron 15 milligrams (mg) to be discontinued at bedtime (HS). On 05/09/11, the physician accepted the recommendation made by the pharmacy to discontinue the Remeron. On 5/10/11, an order was written to discontinue Remeron 15 mg at HS. Resident #3 continued to receive Remeron 15 mg at HS from 05/10/11 through 05/17/11. The resident was sent out to the hospital on 05/18/11 and returned to the facility on 05/21/11. Remeron 15 mg at HS was continued upon his/her return from the hospital until it was discontinued on 06/29/11, with the last dose being administered on 06/28/11 at 9:00 PM. An interview with the Director of Nursing (DON) and the Nurse Consultant, on 06/29/11 at 5:10 PM, revealed Resident #3 received Remeron 15 mg at HS even after the pharmacy's recommendation and a physician's order for discontinuation on 05/10/11. The DON and Nurse Consultant confirmed that Resident #3 received Remeron 15 mg at HS until discontinuation on 06/29/11 and that the medication was not discontinued by the staff as ordered on 05/10/11. They revealed the	F 281	F281 1. Resident #3 is no longer receiving Remeron effective 6/29/11. 2. Current Medication Administration Records for all in-house residents reviewed by nursing administration to ensure no residents continue to receive medications that have been discontinued by physician. 3. All licensed nurses and medication aides have been retrained on the center policy and procedure for physicians orders and medication administration to include procedure for transcription of orders and requirement to discontinue medications on MAR when order to discontinue received by physician. No licensed nurse will work after 8/2/11 without receiving this education. 4. All physicians orders will be reviewed daily Monday-Friday by the Director of Nursing, the Assistant Director of Nursing and/or the Unit Managers and the changes compared to the Medication Administration Record to ensure physicians orders are being followed. The Director of	

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F 281	Continued From page 3 physician was unaware, until 06/29/11, that Resident #3 had continued to received Remeron at HS through 06/28/11.	F 281	Nursing will report findings to the center Quality Assurance Team monthly for three months for review and recommendations.	8/3/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure one resident (#2), in the selected sample of three, received appropriate care and services to maintain a urinary catheter drainage bag. The resident was observed holding a urinary drainage bag at shoulder level next to his/her face while ambulating. Findings include: A review of the facility's policy, undated, revealed "Always make sure the urine drainage bag is secured at a level lower than that of the person's bladder. Raising the urine drainage bag up higher than the bladder can cause old, contaminated urine to run back into the bladder, which can lead to infection."	F 315	F315 1. Resident #2 no longer resides in the center. 2. All other residents with catheters have been reviewed and all were found to be positioned below the residents' bladders. No other center residents require leg bags. 3. All nursing staff have been retrained on the center policy and procedure for positioning and use of catheter bags. A leg bag is now kept in the center central supply for immediate availability. No nursing staff will work after 8/2/11 without receiving this education 4. The center Unit Managers will visually inspect the residents with catheter bags five days per week times two weeks then weekly times two weeks to ensure continued compliance. Findings will be reported to the center Quality Assurance committee monthly for review and recommendations.	8/3/11

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F 315	Continued From page 4 A record review revealed Resident #2 was admitted to the facility on 06/28/11 with diagnoses to include Schizophrenia, Diabetes Mellitus, Hyponatremia and Hydronephrosis with Psychogenic Polydipsia. The resident was cognitively impaired and required staff assistance with all activities of daily living. An observation, on 06/29/11 at 10:00 AM, revealed the resident was ambulating per self and held his/her urinary drainage bag from an indwelling catheter at shoulder level near his/her face. An interview was attempted; however, was unsuccessful due to the resident's impaired cognition. Further observation, on 06/29/11 at 12:55 PM, revealed the resident wandered in the hall and held the urinary drainage bag at shoulder level near his/her face. The resident then sat in a chair with the urinary drainage bag resting on his/her lap. An interview with the Unit Manager, on 06/29/11 at 5:30 PM, revealed the urinary drainage bag should be kept below the bladder. The resident was anxious and pacing and a leg bag for urinary drainage was not available. An interview with the Central Supply Manager, on 06/29/11 at 5:35 PM, revealed there was not a need for a leg bag and was not available in the facility supply inventory. She stated she just went to the medical supplier to obtain one. An interview with the Director of Nursing (DON), on 06/29/11 at 1:15 PM, revealed she expected	F 315		

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F 315	Continued From page 5 indwelling catheter drainage bags to be positioned below a resident's bladder.	F 315		
F 371 SS=D	483.35(i) 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 observations, interviews and review of facility policy, it was determined the facility failed to store, prepare and serve food under sanitary conditions. Observations of the kitchen, on 06/29-30/11, revealed a black substance on the ceiling of the dish room. An observation of the resident's food tray preparation, on 06/30/11, revealed temperatures were not obtained for the frozen egg omelets prior to serving. Findings include: 1. Observations, on 06/29/11 at 11:50 AM and 06/30/11 at 7:15 AM, revealed a black substance around the vent in the dish room. An interview with the Dietary Manager, on 06/30/11 at 7:15 AM, revealed she was not sure what the black substance was and thought it might be dust. She revealed the ceiling surface	F 371	F371 1. The black substance around the vent in the dish room has been removed. The microwave in the dietary department has been replaced. No residents were served the un-temped omelets. 2. All ceiling areas in the dietary have been assessed and cleaned as necessary. All food temperatures recorded since 7/1/11 have been audited and found to be within federal guidelines. 3. All dietary staff have been retrained on the center policy for storing, preparing and serving food under sanitary conditions by the center's consultant dietitian. A cleaning schedule has been established for ceiling areas in the dietary department. All dietary staff have been retrained on the center's policy for obtaining food temperatures prior to serving on all items served. No dietary staff member will work after 8/2/11 without receiving this education	

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F 371	Continued From page 6 area of the kitchen was not on a schedule for cleaning and staff would "tell maintenance" when they thought it needed to be cleaned. The Dietary Manager could not recall the last time the ceiling surface was cleaned. An interview with the Maintenance Supervisor, on 06/30/11 at 9:30 AM, revealed housekeeping dusted the ceiling surface if needed; however, maintenance was responsible to scrape, apply Kiltz and paint black discolorations that could not be removed by dusting. He revealed he was not aware of the black substance on the ceiling in the dish room of the kitchen. 2. A review of the facility's policy for food temperatures, dated 11/00 and revised 07/04, revealed "accurate temperatures will be taken using a thermometer during preparation, cooking and meal service." An observation of the resident's food tray preparation, on 06/30/11 at 7:55 AM, revealed 6-7 frozen egg and cheese omelets on a plate by the microwave. The cook was observed to place one omelet, for a requested test tray, in the microwave three different times. She then plated the omelet and sent it down the tray line. Additionally, the cook plated one omelet, for a resident's tray, and did not heat it in the microwave. No temperatures were obtained for any of the egg and cheese omelets served. An observation on 06/30/11 at 8:10 AM, revealed the temperature, at point of service, of the test tray egg omelet was 105 degrees Farenheit (F). The omelet that was not heated in the microwave was 60 degrees F at 8:14 AM.	F 371	4. The Dietary manager or Assistant or designee will monitor food preparation and temperatures prior to every meal daily times two weeks then at twice daily times two weeks. The Dietary Manager, Assistant Manager or NHA will check the ceiling areas for dust daily five days per week. Findings will be reported to the center Quality Assurance Committee monthly times three months for review and recommendation.	8/3/11

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F 371	Continued From page 7 A review of the directions for heating the frozen egg and cheese omelets revealed they were to be placed frozen in a dish, covered with plastic and heated for one to one and a half minutes. An interview with the Cook, on 06/30/11 at 8:30 AM, revealed the microwave did not work properly and she had to unplug the microwave, plug it back up and attempt to heat the omelets repeatedly. The microwave displayed F12 on the indicator and the cook did not know the meaning of the display. The cook stated the microwave had not functioned properly for a few days and thought someone knew about it. Additionally, the cook stated she had never checked the temperature of the omelets or any other food that had been warmed in the microwave. An interview with the Dietary Manager, on 06/30/11 at 8:15 AM, revealed omelets were special ordered by certain residents. The omelets came in a case box and only a few were removed at a time and set aside. The cook heated individual omelets just prior to plating them. She stated the cook touched the omelet with a gloved finger to check the temperature. If the omelet was not hot enough, then the temperature was taken with a food thermometer.	F 371		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469	F469 1. Room #451 and resident hall 400 were deep cleaned to remove any substances that might attract flies. 2. All areas of the center where flies were present have been cleaned.	

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F 469	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to maintain an effective pest control program to ensure the facility was free from pests. Observations revealed multiple flies were in the building and a large number of flies were observed in a resident's room. Findings include: An observation of Room #451, on 06/29/11 at 10:10 AM, revealed multiple flies were observed on the bed, concentrated in a corner by the sink and flying around the room. Observations of the 400 Hall, on 06/30/11 at 6:00 PM and on 07/01/11 at 7:10 AM and 9:45 AM, revealed multiple flies were observed flying around the area. An observation, on 06/29/11 at 10:15 AM, revealed Resident #8 was holding a fly swatter. An interview with the resident revealed his/her family brought the fly swatter from home because the flies were everywhere and were very annoying. An interview with Housekeeping Staff # 1, on 06/30/11 at 9:45 AM, revealed the 400 Hall area was her usual assignment. She stated the flies were "bad" and several residents kept fly swatters at the bedside to try and keep them under control. An interview with the Maintenance Supervisor, on 07/01/1 at 10:55 AM, revealed the facility had a contract with a pest control company. Glue traps with lights and blowers at the entrances were	F 469	3. Center supply vendors have been instructed to bring deliveries in thru doors with air curtains only to reduce the chances of flies being admitted. The center pest control company installed an additional six bait stations outside the center and changed the glue traps throughout the center. Center staff have been retrained on reporting pests to the maintenance supervisor for follow up to the pest control company. No staff will work after 8/2/11 without receiving this education. 4. Maintenance Supervisor and/or Administrator will make center rounds five times weekly for two weeks and weekly thereafter to ensure there no recurrence of the pest problem. Findings will be reported monthly times three months to the center Quality Assurance team for review and recommendation.	8/3/11

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F 469	Continued From page 9 utilized in an attempt to control the flies. The pest control company was called to the facility on 06/27/11 and treated Room #451 and felt the treatment "was effective for the most part." No other explanation was provided for the multiple flies observed in Room #451.	F 469		