PRINTED: 08/04/2010
FORM APPROVED
OMB NO. 0938-0391

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 A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	105435		07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER	1381 CAMPBELL LANE BOWLING GREEN, KY 42104

RECEIVED AUG 2010 OFFICE OF INSPECTOR GENERAL

(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 000	INITIAL COMMENTS A standard recertification survey was conducted on 07/20/10 through 07/22/10 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D".	F 000	"This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Magnolia Village Care and Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency, statements, facts, and conclusion that form the basis for the deficiency.	
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 observations, interviews, and record review, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality for one resident (#7), in the selected sample of 15. The facility failed to implement physician's orders regarding the discontinuation of a body (clip) alarm and the implementation of a sensor alarm for the resident's wheelchair. Findings include: Resident #7 was admitted to the facility, on 10/01/06, with diagnoses which included Advanced Alzheimer's Type Dementia, Peripheral Vascular Disease and Seizure Disorder. A review of the physician orders, dated 06/29/10 (for the time period of 07/01-31/10), revealed an order to "Check alarm for proper placement and working condition every shift, sensor alarm in chair and under mattress alarm on bed." Further review of the physician order, dated 03/15/10, revealed a body alarm was used in bed and a wheelchair and the discontinuation of the body	F 281	F281 With respect to resident(s) affected by the alleged deficient practice: Resident #7 has been assessed and the medical record reviewed to ensure that the ordered alarm type is in use. The physician order was obtained for the alarm by the Assistant Director of Nursing on 8/6/2010. The treatment record was up-dated by the Assistant Director of Nursing on 8/6/2010, to reflect the use of the alarm each shift. The CNA care card and the nursing plan of care were also revised by the Assistant Director of nursing to reflect the use of the alarm. With respect to resident(s) having the potential to be affected by the alleged deficient practice: All current residents requiring the use of alarms have been assessed and the medical records were reviewed by the Assistant Director of Nursing on 8/8/2010, to ensure the correct type of alarm is in use and documentation in place for the alarms; including MD order, nursing care plans, CNA care card and the treatment records.	F 281 8-16-2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marla Stapleton RN BSN NHA
TITLE:
(X8) DATE: 8-13-10

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

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	185435		07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 1 (clip) alarm. The individual staff listed as documenting the discontinuation order was the Director of Nursing (DON)/acting Administrator. An observation, on 07/20/10 at 6:40 AM, revealed Resident #7 was asleep in bed with a sensor alarm applied to the bed. A wheelchair was observed by Resident #7's bed which had a body (clip) alarm attached to the back of the wheelchair. Observations, on 07/20/10 at 11:15 AM, at 12:00 PM, and at 12:45 PM, revealed Resident #7 was in a wheelchair with the body alarm attached to the back of the wheelchair, but the clip was not attached to the resident. Observations, on 07/21/10 at 9:15 AM and at 1:20 PM, revealed the resident was in the wheelchair and the body alarm was clipped to the resident's clothing. Interviews with Certified Nursing Assistants (CNA) #1, #2, and #3, on 07/22/10 at 2:00 PM, at 2:02 PM, and at 2:05 PM, respectively, revealed Resident #7 always wore the body (clip) alarm when in the wheelchair. None of the CNAs could recall the resident utilizing a sensor alarm when in the wheelchair. An interview with the DON/acting Administrator, on 07/22/10 at 2:25 PM, revealed Resident #7 had a body (clip) alarm applied to the bed and wheelchair, prior to 03/15/10. She stated she had slowly replaced all clip alarms with sensor alarms because she felt the sensor alarms were more effective. The DON had no explanation as to why the sensor alarm was placed on Resident #7's bed, but not on the wheelchair. She stated it was the responsibility of the nurse, who took the order, to ensure it was implemented.	F 281	With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recure: All current licensed and unlicensed staff have been educated by the Assistant Director of Nursing to the procedure for instituting, maintaining and evaluating the use of alarms. Orders for the alarms will be reviewed by nursing management during the stand up meeting process to ensure orders, assessments, care plans and CNA care cards are complete. With respect to how the facility will monitor performances to ensure that solutions are sustained: The Director of Nursing will monitor the ongoing compliance of alarm use to ensure that staff are following procedures by conducting visual audits weekly for three weeks. The findings from the audits will be reported to the PI committee each month for three months for any further recommendations.	
F 311	483.25(a)(2) TREATMENT/SERVICES TO	F 311	F311 With respect to the resident(s) affected by	F 311 8-16-2010

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NAME OF PROVIDER OR SUPPLIER MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1381 CAMPBELL LANE BOWLING GREEN, KY 42104	

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F 311 SS=D	Continued From page 2 IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to provide restorative services to maintain and/or improve ambulation for one resident (#3), in the selected sample of 15. Findings include: A review of the facility's policy and procedure (MDS book) for restorative services revealed restorative services were nursing interventions that assisted or promoted the resident's ability to attain his or her maximum functional potential. For ambulation activities to improve or maintain the resident's self-performance in walking, with or without assistive devices. A record review revealed Resident #3 was admitted to the facility with diagnoses of Senile Dementia and Osteoporosis. A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/24/10, revealed the facility assessed Resident #3's decisions as poor and he/she required supervision. The assessment revealed the resident required limited assistance of one staff member for ambulation. Attempts to interview the resident were unsuccessful, on 07/20/10 at 7:15 AM and at 11:15 AM.	F 311	the alleged deficient practice: Resident #3 has been evaluated and restorative nursing program developed by the Assistant Director of Nursing on 8/6/2010, to maintain and/or improve ambulation for this resident. With respect to the resident(s) having the potential to be affected by the alleged deficient practice: All current residents with restorative programs have been evaluated and the medical records reviewed by the Assistant Director of Nursing on 8/5/2010, to ensure that restorative programs are in place for these residents. With respect to measures to effect systematic changes to ensure the alleged deficient practice does not recur: All staff licensed and unlicensed have been re-educated by the Assistant Director of Nursing before 8/14/2010 as to the restorative protocols and have demonstrated competency of these programs. With respect to how the facility will monitor performances to ensure that solutions are sustained: The Director of Nursing will monitor this process by reviewing weekly monitoring for three weeks, completed by the Assistant Director of Nursing, including visual audits of restorative programs to ensure that residents' restorative programs are performed according to the restorative plan of care. Monthly reports will be submitted by the ADON for three months to the PI Committee for further recommendation.	

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	186435		07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 311	Continued From page 3 A review of the Restorative Program developed for Resident #3, with a start date of 07/13/10, revealed the resident would ambulate 2-3 times a day to all meals as part of the walk-to-dine program. The intervention stated the resident would walk to three meals each day, using a rolling walker. The resident ambulated 250 feet with rolling walker with contact guard assistance and minimum assistance and cues for safety. A review of the July 2010 Restorative Flow Sheet revealed the facility staff ambulated Resident #3 to the dining room one time a day for five of nine days. Observations, on 07/20/10 at 7:15 AM (breakfast meal) and at 11:15 AM (lunch meal) and on 07/21/10 at 11:10 AM (lunch meal), revealed Certified Nurse Aide (CNA) #4 approached Resident #3 while the resident was seated in the wheelchair and told Resident #3 she would assist him/her to the dining room to eat. The CNA pushed Resident #3 in the wheelchair all the way to the dining room. The CNA did not offer to ambulate the resident on any occasion. An interview with Restorative Aide (RA) #1, on 07/21/10 at 1:45 PM, revealed Resident #3 was supposed to be assisted to ambulate to the dining room for meals. He stated he usually assisted Resident #3 to ambulate to the dining room in the evening. When asked if Resident #3 was assisted to ambulate to the dining room for other meals, he stated it depended on how busy staff were; but the resident was usually assisted to ambulate. He provided no explanation as to why Resident #3 had not been assisted to ambulate to the dining room at least two times a day, per care	F 311		

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F 311	Continued From page 4 plan, during five of nine days in July 2010. Interviews with CNA #3 and CNA #4, on 07/21/10 at 1:40 PM and on 07/22/10 at 1:05 PM, revealed Resident #3 sometimes refused to ambulate. CNA #3 stated she had not worked with the restorative program the past couple of days. She stated RA #1 completed the Restorative care, on 07/20/10 and 07/21/10. The RA was supposed to assist the resident to ambulate to the dining room. An interview with the Assistant Director of Nursing/Restorative Program Manager, on 07/22/10 at 12:45 AM, revealed the RAs completed the walk-to-dine program. She stated most the CNAs had been trained regarding restorative care, so they could help out with restorative, when needed. She did not provide an explanation as to why Resident #3 did not receive ambulation to the dining room two times a day for five out of nine days in July 2010.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to provide adequate supervision to prevent	F 323	F 323 With respect to resident(s) affected by the alleged deficient practice: Residents # 3, #7 and #12 have been assessed and the medical record reviewed by the Assistant Director of Nursing on 8/5/2010, to ensure interventions are in place to maintain residents at the highest practicable level of safety. Device assessments have been completed by the Assistant Director of Nursing on 8/5/2010, for the devices determined of need for these individuals.	F 323 8-16-2010

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F 323	Continued From page 5 accidents and/or to ensure the environment was free of accident hazards for three residents (#3, #7, and #12), in the selected sample of 15. The facility failed to implement its' established policy and procedures related to assessment, implementation and monitoring of assistive and/or restrictive devices for Residents #3, #7 and #12. Findings include: A review of the facility policy entitled "Restrictive Device Management Program", dated January 2008, revealed under the section entitled "Assessment: Identifying Residents in Need of a Device", if a resident was determined to need an assistive or restrictive device, the licensed nurse completed a restrictive device evaluation. The licensed nurse completed the evaluation to determine the medical necessity of the device. Evaluating was an extremely important step, because once residents' device needs were identified, appropriate interventions were implemented. Devices could be categorized as either an enabler, a reminder, assistive, or restrictive. A review of the facility's "falls management program", dated January 2008, revealed the facility would identify residents at risk for falls, implement interventions to prevent falls, ensure a safe environment, reduce the likelihood of injury and manage falls which occurred in the facility. The licensed nurse/designee would check for the placement and function of alarms, at least daily. The licensed nurse would document the checks on the Treatment Administration Record (TAR). If a device, alarm or restrictive device was identified as not functioning, the licensed nurse would immediately replace it with an operational device.	F 323	Physician orders have been reviewed for devices/equipment for residents #3, #7 and #12. Nursing care plans, CNA care cards and treatment sheets have been revised to reflect interventions by the Assistant Director of Nursing on 8/15/2010. With respect to resident(s) having the potential to be affected by the alleged deficient practice: All current residents have been assessed by the Assistant Director of Nursing by 8/15/2010 and medical records reviewed for device use. Device assessments have been reviewed and/or revised on 8/5/2010 to ensure the correct device/equipment is in use by the Assistant Director of Nursing. Physician orders were reviewed by the Assistant Director of Nursing on 8/5/2010, to ensure the inclusion of each resident's device. Nursing care plans, CNA Care Cards and treatment administration records were reviewed to ensure the inclusion of the device ordered by the Assistant Director of Nursing. With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recur: All staff were re-educated by the Assistant Director of Nursing by 8/15/2010, as to the protocol for device assessment and use for residents and for the protocol to be used prior to the implementation of any device. Orders for devices will be reviewed by nursing management during the stand up meeting process to ensure orders, assessments, care plans and CNA care cards are complete.	

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F 323	Continued From page 6 1. A record review revealed Resident #3 was admitted to the facility with diagnoses of Senile Dementia and Osteoporosis. A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/24/10, revealed the facility assessed Resident #3's decisions were poor and he/she required supervision. The resident had sustained falls within the past 31-180 days. A review of the Comprehensive Care Plan, dated 04/27/10, for the problem, "risk for falls related to impaired balance, poor coordination and unsteady gait", revealed interventions included two staff to assist the resident with transfers, a sensor alarm on the bed and bedside mats for injury prevention. A review of the Certified Nurse Aide (CNA) Care Plan, dated July 2010, revealed the CNAs were to apply a clip alarm to the resident's wheelchair and a sensor alarm to the bed; but did not address the floor mats to be placed on each side of the bed. A review of the July 2010 Treatment Administration Record (TAR), revealed the facility failed to ensure the use of the floor mats and alarms were transcribed on the TAR in order for the licensed staff to document monitoring activities of the assistive devices. Observations, on 07/20/10 at 1:15 PM, on 07/21/10 at 9:40 AM and on 07/22/10 at 2:10 PM, revealed Resident #3 was lying on his/her back in bed. There were no floor mats on the floor on each side of the bed. Further observation revealed one floor mat was located between the	F 323	With respect to how the facility will monitor performances to ensure that solutions are sustained: The Assistant Director of Nursing along with the Director of Nursing will conduct weekly reviews for three weeks, of the medical record and visual audits of the residents requiring assistive devices to ensure compliance and that residents' plans of care are being followed for proper equipment and device use. The findings from the audits will be reported to the Performance Improvement Committee every month for three months by the Assistant Director of Nursing for further recommendations.	

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F 323	Continued From page 7 headboard and the wall. An observation, on 07/21/10 at 11:10 AM, revealed Resident #3 removed his/her jacket alarm, which was clipped to the resident's jacket and transferred unassisted to the bed from the wheelchair. A CNA came into the room and assisted the resident to lie down in the bed. The resident requested to use the bathroom. The CNA assisted the resident to stand and the sensor alarm on the bed did not alarm. The CNA ambulated the resident to the bathroom. Afterward, the CNA assisted the resident back into the wheelchair and wheeled the resident to the dining room for lunch. The CNA did not check the sensor alarm to determine why the alarm did not sound. An observation, on 07/22/10 at 9:30 AM, revealed the sensor alarm did not sound when pressure was applied to the mattress and released. Observation revealed the alarm box was not intact. The battery compartment was exposed due to the fact there was no back for the box and the battery fell from the box during the examination. An interview with CNA #4, on 07/21/10 at 1:40 PM (provided care for Resident #3 on 07/21/10), revealed she noticed the bed sensor alarm did not sound when she stood the resident up from the bed and she did not report the problem to licensed staff. Additionally, she did not report the resident had removed his/her jacket after removal of the clip alarm and transferred without assistance. She stated the resident should have floor mats on each side of the bed when in bed and provided no explanation for the lack of floor mats. An interview with CNA #5, on 07/22/10 at 10:50	F 323		

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NAME OF PROVIDER OR SUPPLIER: MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1381 CAMPBELL LANE, BOWLING GREEN, KY 42104

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F 323	Continued From page 8 AM, revealed she usually checked bed alarms, chair alarms and floor mats at the beginning of her shift to ensure they were in place and in working order. She was not sure about the use of floor mats for Resident #3. She checked the CNA care plan and found no indication floor mats were to be utilized by the resident's bed. An interview with LPN #2, on 07/22/10 at 12:25 PM, revealed she repaired the alarm box the day before and did not know the box had no back to the battery compartment. An interview with Registered Nurse (RN) #1, on 07/22/10 at 10:45 AM, revealed if the alarms, floor mats or any other assistive devices were implemented as a nursing measure and a physician's order was not received for the device, the nurse would need to key the device into the computer system in order for the use of the device to be transcribed to the TAR. An interview with the Acting Administrator/Director of Nursing, on 07/22/10 at 10:30 AM, revealed when a device was implemented for a resident, staff needed to key the device into the computer to ensure the device was printed onto the TAR. She stated the reason staff needed a physician's order for each device was to ensure the use of a device would be transcribed onto the TAR. 2. Resident #7 was admitted to the facility, on 10/01/06, with diagnoses which included Advanced Alzheimer's Type Dementia and Seizure Disorder. Observations of Resident #7, on 07/20/10 at 11:15 AM, at 2:00 PM and at 12:45 PM, revealed	F 323		

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F 323	Continued From page 9 the resident was in a wheelchair with a body alarm attached to the back of the wheelchair, but the clip was not attached to the resident. An interview with CNA #2, on 07/22/10 at 2:02 PM, revealed she was assigned to provide care for Resident #7 on 07/20/10. She checked the alarms for the residents on her assignment periodically throughout the day. CNA #2 provided no explanation for the unattached body alarm for Resident #7, observed on 07/20/10. An interview with the Director of Nursing (DON)/acting Administrator, on 07/22/10 at 2:25 PM, revealed when an order was taken off as an active treatment, the order should automatically print out on the TAR. The CNAs were responsible for ensuring any alarm was in place, during provision of care. The licensed staff was responsible for monitoring the placement and function of the devices, at least once a shift, when they completed the TAR. She stated the body alarm was not included on the comprehensive care plan, the TAR, or the CNA care plan and she had no explanation for the omission. 3. Resident #12 was admitted to the facility, on 10/01/06, with diagnoses which included Dementia with Behavioral Disturbances and Alzheimer's Disease. A review of nurses notes, dated 06/25/10 at 11:45 PM, revealed the resident was found on the floor by the bed on his/her knees. Resident #12 sustained no injuries and the physician was notified of the fall. After the fall, bilateral bed bolsters were placed on Resident 12's bed. An observation, on 07/21/10 at 1:45 PM, revealed	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185435		07/22/2010

NAME OF PROVIDER OR SUPPLIER
MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1381 CAMPBELL LANE
BOWLING GREEN, KY 42104

(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 323	Continued From page 10 Resident #12 was asleep in bed with a winged mattress and bilateral bed bolsters. An interview with Licensed Practical Nurse (LPN) #1, on 07/22/10 at 8:50 AM, revealed she had documented the incident in the record, on 06/25/10. She stated the resident never rolled out of the bed and the cause of the the fall was not determined. She discussed the use of bolsters with the physician, but did not complete a restrictive device evaluation on the resident, prior to the application of the bed bolsters. Additionally, she did not write a physician order for the device. She stated she did not feel a restrictive device evaluation was needed as she did not feel the device was restrictive. An interview with the DON/acting Administrator, on 07/22/10 at 10:50 AM, revealed all residents should be assessed for any device, prior to application of the device. She stated an assessment would be completed on the restrictive device evaluation form, which would assist in determining if the device was a restraint, an enabler, an assistive device, or a reminder. She stated all devices should have a physician order, prior to application. The DON/acting Administrator revealed she could not find any restrictive device evaluation form or physician order for the use of the bilateral bed bolsters in the clinical record. She further revealed she could not determine when the winged mattress was implemented for Resident #12's bed, but when it was applied the bed bolsters should have been discontinued. She believed at the time of the fall, Resident #12 was using a standard perimeter defined mattress.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334	F 334 With respect to resident(s) affected by	F 334 8-16-2010

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NAME OF PROVIDER OR SUPPLIER MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1381 CAMPBELL LANE BOWLING GREEN, KY 42104	

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F 334	Continued From page 11 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334	the alleged deficient practice: Residents # 6 and #13 medical records have been reviewed for immunization consents/ declinations by the ADON on 8/6/2010. The residents' legal representatives have received education regarding the benefits and potential side effects of immunization. Each resident's medical record has the declination form or the consent form signed by the responsible party by 08/14/2010. Immunizations will be given this influenza season for residents consenting to the immunization. With respect to resident(s) having the potential to be affected by the alleged deficient practice: All current residents' medical records have been reviewed by the Assistant Director of Nursing on 8/6/2010, to ensure the completion of each residents and/or responsible parties education regarding the benefits and potential side effects of immunization have been completed. Each resident will have the declination form or the consent form signed by the responsible party by 08/14/2010. Immunizations will be given this influenza season for all residents consenting to the immunization. With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recur: Licensed staff have been re-educated by the Assistant Director of Nursing by 8/15/2010, regarding the policy and procedures for resident immunizations and have demonstrated understanding of the policy. A log of resident consents/declinations and education on the immunization process will	

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NAME OF PROVIDER OR SUPPLIER MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1381 CAMPBELL LANE BOWLING GREEN, KY 42104	

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F 334	Continued From page 12 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to offer the flu vaccine for two residents (#6 and #13), in the selected sample of 15. Resident #6 and #13 did not receive the 2009 influenza vaccine. The residents' consent forms had not been returned to the facility by the guardians and the facility assumed the failure to return the forms represented a refusal. Findings include:	F 334	be developed and maintained by the Assistant Director of Nursing. With respect to how the facility will monitor performances to ensure that solutions are sustained: The Assistant Director of Nursing will provide education to all new licensed staff regarding resident immunizations. A log will be maintained for all residents with new residents added by the ADON. This log will be reviewed prior to each influenza season to ensure that each resident's responsible party has been educated as to the risks and benefits of immunization and have either a consent or declination in their medical record. The DON will monitor this process by reviewing this documentation each influenza season to ensure that all residents are immunized accordingly. Results of the audits will be reported to the Performance Improvement Committee monthly for three months for further recommendations.	

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NAME OF PROVIDER OR SUPPLIER: MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1381 CAMPBELL LANE, BOWLING GREEN, KY 42104

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F 334	Continued From page 13 1. A record review revealed Resident #13 was admitted with diagnoses to include Dementia with Behavior Disturbances, Psychosis, Anxiety and Hypertension. A review of the physician's orders, dated 11/06/09, revealed an order for the "annual influenza vaccine if not allergic to eggs". A review of the immunization record revealed there was no consent form or documentation of receiving or refusing the influenza vaccine for the current year. 2. A record review revealed Resident #6 was admitted with diagnoses of a closed fracture of the pelvis and Depression. A review of the physician's orders, dated 11/2009, revealed an order for the "annual flu vaccine if not allergic to eggs". A review of the immunization record revealed there was no consent form or documentation of Resident #6 receiving or refusing the flu vaccine for the current year. A review of an immunization report revealed the resident refused the vaccine, on 01/05/10. An interview with the acting Director of Nursing (DON), on 07/22/10 at 1:05 PM, revealed she was responsible for obtaining the consent forms for residents to receive the yearly influenza vaccine. The consent forms were mailed with the August billing to the responsible party. The responsible party of Residents #6 and #13 did not return the consent forms to the facility. The DON stated when a consent form was not returned to	F 334		

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	185435	A. BUILDING 01 - BUILDING B. WING _____	07/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA VILLAGE CARE AND REHABILITATION CENTER	1381 CAMPBELL LANE BOWLING GREEN, KY 42104

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 07/21/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

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

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