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

PRINTED: 09/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2010

NAME OF PROVIDER OR SUPPLIER: OWENSBORO PLACE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1205 LEITCHFIELD RD. OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey was conducted 08/25/10 through 08/27/10 to determine the facility's compliance with Federal Regulatory Requirements. Deficiencies were identified with the highest S/S being a "E". Additionally, an abbreviated survey was conducted 08/25/10 through 08/27/10 for KY #15207 and KY #15208. Both complaints were determined to be unsubstantiated with no deficiencies cited.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owensboro Place 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 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	It is the intent of this facility to provide the best possible care to all our residents and to insure that the resident has the right to personal privacy and to confidentiality of his or her personal and clinical records. Residents 12, 25, 26, and 27 have been assessed by Social Services regarding privacy and dignity. No negative outcome was identified. All residents of the facility have the potential to be affected. The DNS, ADNS, Unit Managers, and Charge Nurses will make rounds daily to ensure privacy curtains are drawn and doors are closed when care is provided. Concerns will be addressed immediately. All staff members received re-education training on 8/26/2010 by the SDC and on 9/9/2010 by the Director of Nursing and the Administrator regarding the facility policy on Resident's Rights to include personal privacy and confidentiality. Monitoring will be completed by a nurse manager five times per week for four weeks then weekly for eight weeks to include privacy curtains are drawn and doors are closed when care is provided. The Personal Privacy and Confidentiality monitoring tool will be reviewed monthly for three months during the Performance Improvement (QA) Committee meeting for the purpose of identifying any Personal Privacy and Confidentiality issues.	10/1/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendell A. Smith — TITLE: Administrator — (X6) DATE: 9/16/10

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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	185236		08/27/2010

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F 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure privacy was provided for one resident (#12), in the selected sample of 24, related to wound care and catheter care. Additionally, privacy was not provided for three residents (#25, #26 & #27), not in the selected sample, related to grooming and toileting needs. Findings include: 1. A record review revealed Resident #12 was admitted to the facility on 11/11/09 with diagnoses to include Adult Failure to Thrive, Anxiety, Depressive Disorder, Paraplegia, Hypertension and Pressure Ulcer lower back. A review of the significant change Minimum Data Set (MDS) assessment, dated 07/13/10, revealed the resident was assessed as requiring total assistance with all activities of daily living (ADLs). Further review of the MDS, revealed the resident had a Stage IV wound on his/her coccyx area and a catheter in place for wound healing purposes. An observation, on 08/27/10 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #2 completed a treatment/dressing change of a Stage 4 pressure sore on Resident #12's coccyx area. Certified Nurse Aide (CNA) #1 assisted the LPN by holding the resident in position to complete the treatment/dressing change. After the dressing change was completed, catheter care was provided by LPN #2 and incontinent care was provided by another CNA (#2). During provision of	F 164		

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F 164	Continued From page 2	F 164		

care by LPN #2, CNA #1 and CNA #2, the privacy curtain was not completely pulled around the resident and the resident's door was not closed.

An interview with LPN #2, on 08/27/10 at 10:25 AM, revealed the resident's door would not close because of the bed. Additionally, she stated, she usually pulled the curtain all the way around the resident; however, she failed to do that this time and provided no further explanation as to why.

2. A record review revealed Resident #25 was admitted to the facility on 10/26/06 with diagnoses to include Alzheimer's Disease and Muscle Disuse Atrophy.

A review of the quarterly MDS assessment, dated 08/06/10, revealed the resident was assessed as requiring total assistance with all ADLs.

An observation on 08/27/10 at 11:10 AM, revealed two CNAs (#1 and #2) assisted the resident to dress. The privacy curtain was only partially pulled around the resident and the door to the hallway was open.

An interview with the two CNAs on 08/27/10 at 1:45 PM, revealed no explanation as to why privacy was not afforded to this resident.

3. A record review revealed Resident #26 was admitted to the facility on 07/07/05 with diagnoses to include Alzheimer's Disease, Abnormality of Gait and Paralysis Agitans.

A review of the quarterly MDS assessment, dated 07/19/10, revealed the resident was assessed as requiring total assistance with all ADLs.

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F 164	Continued From page 3 An observation, on 08/27/10 at 11:30 AM, revealed two CNAs (#1 and #2) assisted Resident #26 with a bed bath. The privacy curtain was only partially pulled around the resident and the door to the hallway was open. An interview with the two CNAs, on 08/27/10 at 1:45 PM, revealed no explanation regarding privacy issues for the resident. 4. A record review revealed Resident #27 was admitted to the facility on 07/01/05 with diagnoses to include Alzheimer's Disease, Muscle Weakness (Generalized)BS Abnormality of Gait. An observation on 08/25/10 at 10:45 AM, revealed Resident #27 was in his/her bathroom while CNA #3 assisted him/her with toileting. CNA #3 did not close the door to the resident's room or bathroom. The resident's roommate was able to see in the bathroom, while Resident #27 was being toileted. An interview with CNA #3, on 08/27/10 at 2:35 PM, revealed Resident #27 required assistance during toileting, and did not like the door to be shut when he/she was in the bathroom. She further revealed the privacy curtain should have been pulled around so the resident's roommate was not able to see into the bathroom. She stated, "I understand I did not provide privacy, but it has never been a problem for the resident." An interview with the Director of Nursing (DON), on 08/27/10 at 2:00 PM, revealed she expected privacy to be provided for all residents. A review of the facility's policy/procedure "Resident Rights" (undated) revealed, "Our facility	F 164		

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F 164	Continued From page 4 has determined that each of our residents have the right to privacy concerning accommodations and medical treatment."	F 164		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure staff members washed their hands or changed gloves before, during or after direct contact with one resident (#12), in the selected sample of 24. Findings include: A record review revealed Resident #12 was admitted to the facility on 11/11/09 with diagnoses to include Adult Failure to Thrive, Anxiety, Depressive Disorder, Paraplegia, Hypertension and Pressure Ulcer lower back. A review of the significant change Minimum Data Set (MDS) assessment, dated 07/13/10, revealed the resident was assessed as requiring total assistance with all activities of daily living (ADLs). Further review of the MDS, revealed the resident had a Stage IV wound on his/her coccyx area and a catheter in place for wound healing purposes. An observation, on 08/27/10 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #2 completed a treatment of a Stage 4 pressure sore on Resident	F 444	It is the intent of this facility to provide the best possible care to all our residents and to insure that hand hygiene is practiced before and after the provision of care, including wound dressings and catheter care. Audits are completed by nurse managers to ensure resident #12 has treatments and procedures performed per facility standards and expectations to prevent infection. All residents have the potential to be affected by the cited practice. All staff members received re-education training on 8/26/2010 by the SDC and on 9/9/2010 by the Director of Nursing and the Administrator regarding the facility policy on hand washing before and after providing care, including contacting blood and body fluids (secretions or excretions), contaminated items, immediately after gloves are removed, and when otherwise indicated to avoid the transfer of microorganisms to themselves or other residents. The DNS, ADNS, Unit Managers, and Charge Nurses will make rounds to ensure staff members are washing their hands before and after providing care and between catheter care and wound dressing changes. Any concerns will be addressed immediately. The Infection Control monitoring tool results will be reviewed by the Performance Improvement (QA) Committee monthly for three months unless otherwise indicated.	10/1/10

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F 444	Continued From page 5 #12's coccyx area. Certified Nurse Aide (CNA) #1 assisted LPN #2 by holding the resident in position to complete the treatment. Prior to the treatment, LPN #2 or CNA #1 did not wash their hands before they donned clean gloves for the dressing change. Upon completion of the dressing change, LPN #2 and CNA #1 removed their gloves; however, they did not wash their hands. CNA #1 left the room after the dressing change. The LPN donned new gloves and proceeded with the resident's catheter care. Upon completion of the catheter care, the resident was incontinent of bowel. Incontinent care was provided by CNA #2, who also worked that hall with CNA #1. LPN #2 removed her gloves after the catheter care and donned new gloves to assist CNA #2 with the incontinent care. Again, the LPN did not wash her hands prior to donning new gloves. Once the incontinent care was completed, LPN #2 went to the resident's bathroom, removed the glove from her left hand, came out of the bathroom after rinsing out the wash basin, then picked up the soiled washcloth off the bed and carried the soiled washcloth up the hallway with her gloved right hand. An interview with LPN #2, on 08/27/10 at 10:25 AM, revealed she had washed her hands at the nurses' station prior to entering the resident's room. When she entered the room, she donned clean gloves for the resident's dressing change. She stated after the dressing change, she removed her gloves; however, she did not wash her hands before donning more gloves to provide the resident's catheter care. Additionally, she stated after the catheter care, she removed her gloves and donned more gloves to assist with the incontinent care, but she did not wash her hands until she left the resident's room. She stated she	F 444		

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F 444	Continued From page 6 did not realize what she had done until it was too late. No further explanation was provided other than she did not usually do wound care and catheter care all at one time. An interview with CNA #1, on 08/27/10 at 11:00 AM, revealed she had washed her hands in the shower room on the hallway prior to entering the resident's room and after exiting from the resident's room; however, no handwashing was completed during provision of care while in the resident's room. An interview with the Director of Nursing (DON), on 08/27/10 at 2:00 PM, revealed she expected the staff to wash their hands after entering a resident's room to provide care and prior to leaving the resident's room. Additionally, handwashing was to be completed between a dressing change and catheter care. A review of the facility's policy/procedure "Hand Hygiene" (undated) revealed, "touching blood, body fluids, secretions, excretions, contaminated items, immediately after gloves are removed, between resident contacts and when otherwise indicated to avoid transfer of microorganisms to other residents or environmental surfaces. It is necessary to wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites."	F 444		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	It is the intent of this facility to provide the best possible care to all our residents and to insure laboratory services are provided in a timely manner. Resident #2 was assessed on 8/24/2010 and no signs or symptoms of a urinary tract infection were noted. All residents have the potential to be affected by the cited practice.	10/1/10

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F 502	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to provide timeliness of laboratory services for one resident (#2), in the selected sample of 24. A urine culture result was not provided to Resident #2's physician within the timeframe normal for appropriate intervention. Findings include: A record review revealed Resident #2 was admitted to the facility on 09/15/09 with diagnoses to include Paralysis Agitans, Type II Diabetes with Neuropathy, Gastroparesis, Functional Urinary Incontinence, Hypopotassemia, Hyperlipidemia, Unspecified Essential Hypertension. A review of a physician's order, dated 07/24/10, revealed a standard lab order to obtain urine for a urinalysis (UA) with culture and sensitivity (C&S). Further record review revealed results of a UA were collected on 07/24/10 with C&S results pending. No C&S results were found in Resident #2's record during the survey process. Interviews with Licensed Practical Nurse (LPN) #1, on 08/26/10 at 10:20 AM and at 2:20 PM, revealed the normal procedure for obtaining laboratory services on the weekend was to send the specimen to the hospital lab. All ordered labs were supposed to be placed on the facility's lab tracking record, located at the nurses' station, for follow-up. She further revealed she received results of the UA from the hospital lab on 07/25/10 and notified the physician. An order was received to notify the Advanced Registered Nurse Practitioner (ARNP) to take care of it on the	F 502	Labs, including those on the weekend, will be placed on the shift report and the laboratory tracking log. Both will be reviewed in the morning Clinical Stand Up Meeting and the afternoon Clinical Stand Down Meeting. Weekend Supervisors will monitor shift reports and the Laboratory Tracking Logs to ensure lab reports are received and follow up is performed. Staff members received re-education training on 8/26/2010 by SDC and on 9/9/2010 by the Director of Nursing and the Administrator regarding the procedures for monitoring when lab results are received, when the physician is notified and any orders are obtained, notification of the family/RP, and placement on the 24-hour Report of Residents' Change of Condition and the facility laboratory tracking log to ensure follow up on all labs. The DON will monitor compliance with the facility procedures for the 24-hour Report of Residents' Change of Condition and the Laboratory Tracking Log 5 times per week for four weeks during the standup process and report the findings monthly for three months to the Performance Improvement (QA) Committee. Any issues will be addressed through a new or revised improvement plan.	

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F 502	Continued From page 8	F 502		

following Monday. She stated, " I don't remember putting the lab order on the lab tracking record and to be honest, I may have forgotten to." She revealed she could not find the results of the C&S in the resident's record. Additionally, there was no evidence in the resident's record that follow-up had been completed by the ARNP.

An interview with the ARNP, on 08/26/10 at 11:00 AM, revealed she was in the facility on 07/26/10 and wrote on the UA results to obtain a C&S. She stated, "I typically write an order on the C&S itself; however, if no orders were needed, I would have just initialed and dated that I had seen the results." She further revealed after reviewing the results of the C&S, she would have treated Resident #2, because there were four different antibiotics that could have been used for Resident #2's urinary tract infection.

An interview with the Director of Nursing (DON), on 08/27/10 at 9:35 AM, revealed all nursing wings were to use the lab tracking record to follow-up with the ordered labwork. The charge nurses' were responsible for updating the lab tracking record. She stated there were no in-services completed to ensure the nursing staff was educated, and there was no specific policy regarding labwork. She further revealed she expected the nurses to use the lab tracking record to follow-up with ordered labwork.

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 08/25/10 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

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