

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

PRINTED: 08/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/03/2012
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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 458 BURNLEY RD. SCOTTSVILLE, KY 42164
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED 08/24/12 F490 changed "though" to "through"</p> <p>A recertification survey was conducted on 07/31/12 through 08/03/12. Immediate Jeopardy was identified on 07/31/12 at 42 CFR 483.75 Administration and determined to exist on 07/31/12. The facility was notified of the Immediate Jeopardy on 07/31/12.</p> <p>Based on observation, interview, and record review, it was determined the facility failed to have detailed written plans and procedures that addressed the mechanisms used to unlock emergency exit doors so that facility staff could evacuate residents in the event of an emergency. Additionally, the facility failed to periodically review the procedures with staff related to the use of these mechanisms to unlock the emergency exit door in the event of an emergency or disaster. Observations and interviews with facility staff revealed the emergency exit doors were locked at all times. Further observations and interviews revealed four staff was unable to readily unlock the emergency exit doors using their identification badges and was not aware of the pass code to unlock the emergency exit doors. Interviews and review of the facility's inservices and training revealed the staff was trained in the use of the employee badges to exit the facility through the emergency exit doors when hired; however, there was no evidence the facility made staff aware of the passcode to bypass the emergency exit doors if staff did not have their badges or the badges failed to function. Furthermore, the facility failed to conduct periodic reviews with the staff on the use</p>	F 000	<p>This plan of correction is offered as an attempt to provide the highest level of quality services possible to the residents at Cal Turner Rehab and Specialty Care and is not an admission that the deficiencies cited are correct.</p> 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>E. A. ...</i>	TITLE Administrator	(X6) DATE 10/02/12
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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 000	Continued From page 1 of the badges and pass codes.  The facility's failure to have detailed written plans and procedures and train staff related to the mechanisms to bypass the locked emergency exit doors in the event of an emergency or disaster has caused or is likely to cause serious injury, harm, impairment, or death to a resident.  Immediate Jeopardy was identified on 07/31/12 and determined to exist on 07/31/12 at 42 CFR 483.75 Administration. An acceptable AoC was received on 08/03/12. The AoC was verified on 08/03/12 and it was determined Immediate Jeopardy was removed, effective 08/02/12, as alleged in the AoC with the scope and severity lowered to an "F," based on the facility's need to continue to evaluate the implementation of changes and quality assurance activities.	F 000	<b>F 157</b> <i>It is the policy of Cal Turner Rehab and Specialty Care and routine practice to notify the physician when there is a significant change in the resident's status.</i>  1. Resident # 11 was identified by the DON on 06/05/12 to be affected and had been assessed on 06/02/12 by RN #3 for any adverse reactions to a Foley Catheter. The resident's Nephrologist was notified on 6/13/12 by the licensed nurse caring for resident #11 regarding the resident's symptoms related to catheter use including frequent sediment noted in catheter tube and documented in the conversation in the progress note dated 6/13/12. the licensed nurse caring for resident #11 followed up with the resident's Urologist on 8/2/12; and new orders for irrigation of the Foley catheter were received. The DON met with RN# 3 on 06/08/12, and education was provided on timely performance and notification of physician with changes in resident's condition. The DON in-serviced RN #3 on 8/4/12 regarding the Policy and procedural guidelines for notification of the physician in the event of a change of condition and to obtain an order for irrigation of an Indwelling Urinary Catheters. The performance of RN #3 was also discussed and education provided by the DON on 8/14/12 to contact the physician with a change of condition, specifically the performance related to the change of condition for resident #11 of the selected sample.	08/23/12	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in	F 157			

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F 157	<p>Continued From page 2 §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy/procedure and review of the facility's investigative report, it was determined the facility failed to consult/notify the physician related to a change of condition for one resident (#11), in the the selected sample of twenty-two (22) residents. The facility failed to follow their "Notification of Physicians" and "Indwelling Urinary Catheters" policy/procedure. On 06/02/12, the facility failed to notify Resident #11's physician when he/she presented with the need to "pee" while having an indwelling catheter, had appearance of being flush and being uncomfortable. Furthermore, the staff completed a catheter irrigation without the physician's order. Family interview revealed the resident was so uncomfortable he/she was crying.</p> <p>Findings include:</p>	F 157	<p>Continued from page 2</p> <p>2. All residents with Foley Catheters since 06/02/12 were identified by the MDS Coordinator on 8/3/12 to determine if any other resident had a change in condition that warranted notification of the physician. None was noted through 8/22/12.</p> <p>3. Beginning 8/3/12 and completed by 8/9/12, the Clinical Educator and Director of Nursing provided in-service training to licensed nursing staff regarding:</p> <ul style="list-style-type: none"> <li>a. resident change in condition criteria requiring the notification of the resident's Physician <ul style="list-style-type: none"> <li>i. including notification of any other physicians and responsible parties when a resident has a change in condition, or symptoms requiring Foley catheter irrigation or to change a Foley catheter</li> </ul> </li> </ul> <p>4. Starting 08/17/12, ongoing weekly monitoring for the next 12 months for changes in resident condition will be conducted by the DON. The MDS Nurse, Charge Nurse, ADON or DON will review the 24 hour nursing reports each week to verify physician notifications did occur for all changes in resident conditions. The monitoring will be conducted weekly for 6 weeks and if no concerns are identified the audits will continue monthly for an additional 6 months. The MDS Nurse, Charge Nurse, ADON or DON will document any identified failures. All failures will be reported to the Administrator and Performance Improvement Committee quarterly.</p> <p>5. Corrective actions were completed by August 23, 2012.</p>		

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F 157	<p>Continued From page 3</p> <p>A review of the facility's policy/procedure, "Notification of Physicians," effective date 04/96, last revised 12/11, revealed "any change in the resident's status warrants a notification call to all attending and consulting physicians on the case."</p> <p>A review of the facility's policy/procedure, "Indwelling Urinary Catheters," revised 12/11, revealed a physician's order is required for bladder irrigation.</p> <p>A record review revealed the facility admitted Resident #11 on 05/29/10 with diagnoses to include Renal Failure, Alzheimer's Disease and Cerebral Vascular Accident. Review of Resident #11's care plan revealed the onset date for the indwelling catheter was 06/11/10. A quarterly Minimum Data Set (MDS), dated 06/05/12, revealed the facility identified the resident with a Brief Interview for Mental Status (BIMS) score of five. The resident had an indwelling catheter and was frequently incontinent of bowel.</p> <p>An interview with Family Member (FM) #1, on 08/02/12 at 7:35 PM, revealed she arrived at the facility on 06/02/12 at approximately 5:15 PM. She stated the resident was in the dining room, and his/her face was red and his/her eyes were watering. She stated the resident kept repeating, "I am trying to pee." She requested a Certified Nurse Aide (CNA) to ask the resident's nurse to come to the dining room. She stated she waited for approximately fifteen (15) minutes, and all the time the resident was straining and appearing to be in discomfort. She stated Registered Nurse (RN) #3 came to the dining room and stated the catheter might be twisted. The family member stated the nurse looked up the resident's pant leg</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>to about his/her knee, and the nurse did not appear to untwist the catheter. She stated that the nurse said his/her bag was full and just put it back in the dignity bag. The family member stated she then texted FM #2, and made her aware of Resident #11's condition. FM #2 stated she was on the way to the facility. FM #1 stated she pushed Resident #11 from the dining room back to the lobby at the nurse's station at around 6:00 PM. She stated the resident had tears rolling down his/her face and was still making grunting sounds. She stated she approached the nurse's desk and advised RN #3 the resident was still hurting. She said the nurse just sat there, but stated she would check the resident when they put him/her to bed. The family member stated the nurse did not tell the CNAs to put the resident to bed. FM #1 stated there was another nurse at the nurse's station. She motioned for us to take the resident to his/her room. The nurse and another staff member took the resident to the bathroom and emptied the catheter bag and irrigated the catheter. FM #1 stated she heard the resident say, "Oh" like he was relieved. FM #1 stated after the nurse irrigated the catheter, the resident filled the bag up again, and then the resident was fine.</p> <p>An interview with FM #2, on 08/02/12 at 6:15 PM, revealed after reviewing her text messages, she had received a text message from FM #1, on 06/02/12 at 5:47 PM and 6:16 PM, stating Resident #1 was "having a hard time peeing and that his/her face was real red." She stated FM #1 said RN #3 said she would check the resident when staff put him/her to bed. FM #2 stated she arrived at the facility at approximately 6:45 PM. She stated she saw Resident #11 had tears</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>rolling down his/her face. She stated RN #3 was sitting at the nurse's station. FM #2 stated FM #1 told her she had made the nurse aware of resident's condition in the dining room, and the nurse told her the catheter was not in a kink, the bag was full, and she would check it later. FM #2 stated FM #1 told her after returning to the nurse's station, she had reported to the nurse another two (2) to three (3) times that Resident #11 was "trying to pee." FM #2 stated RN #3 advised her the catheter had been changed recently. FM #2 stated she told the nurse she did not care. "There is a problem now." FM #2 stated the nurse did not say anything and did not move from her seat. FM #2 stated Licensed Practical Nurse (LPN) #2 stated "Just take the resident to his/her room." She stated the LPN #2 stated "I do not know why RN #3 did not flush the catheter. FM #2 stated LPN #2 took Resident #11 to the bathroom. She stated when the resident came out of the bathroom, he/she was totally different and stated he/she felt fine. FM #2 stated the resident was not red any more. She stated she reported the incident to the Assistant Director of Nursing (ADON) on 06/05/12. She stated she told the ADON what happened over the weekend with RN #3 was unacceptable. She stated she advised the ADON the family did not want RN #3 to provide care for Resident #11 again.</p> <p>An interview with RN #3, on 08/02/12 at 4:50 PM, revealed she was the charge nurse for Resident #11 on 06/02/12. She stated Resident #11 was in the dining room and a family member told her Resident #11 needed to "pee." She stated she assessed the catheter tubing and it was kinked. She stated the catheter started to flow. RN #3</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>stated the resident did not appear to be in any distress or pain. She stated it appeared there was some relief, because the resident was not saying he/she needed to "pee." She stated twenty (20) to thirty (30) minutes later, FM #2 approached her and asked when had the catheter been changed and had the resident had a urinalysis. She further stated because the resident was still having discomfort she thought she would have to change the catheter related to sediment in the resident's urine. She stated while she attempted to get staff to help lay the resident down twice, she saw LPN #2 walking to the resident's room with the family members. She stated LPN #2 had the resident sit on the toilet and she irrigated his/her catheter. There was no documented evidence that the physician was notified by RN #3.</p> <p>An interview with LPN #2, on 08/03/12 at 8:55 AM and 2:45 PM, revealed she recalled the incident related to Resident #11's catheter occurring. Around 6:00 PM, a family member of Resident #11 asked her who the resident's nurse was, because the family member thought the resident was uncomfortable and needed to go to the bathroom. LPN #2 stated she told the family member the resident's nurse was RN #3. LPN #2 stated she was in and out of the dining room during the dinner meal and recalled the family member saying something about Resident #11 being uncomfortable. She stated she observed Resident #11's face being flush while up in the wheelchair. LPN #2 stated at approximately 7:00 PM, the family member and Resident #11 were in the hallway near the resident's room. She stated the resident looked about the same. His/her face was flush. She stated she flushed the catheter.</p>	F 157		

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F 157	<p>Continued From page 7</p> <p>It started flowing and the resident got relief right away. LPN #2 reviewed the physician's orders. She stated there was not a previous physician order for irrigating the catheter. There was no documented evidence the physician was notified by LPN #2 to obtain an order to irrigate the catheter.</p> <p>During initial tour of the facility, on 07/31/12 at 4:10 PM, an observation revealed Resident # 11 had a urinary catheter with a dignity bag, and a family member voiced concerns regarding Resident #11's care related to his/her catheter.</p> <p>A review of the physician's orders for Resident #11, dated 06/02/12, revealed no evidence the facility received an order to irrigate his/her catheter.</p> <p>An interview with RN #2, on 08/03/12 at 2:45 PM, confirmed there was no order to irrigate Resident #11's urinary catheter on 06/02/12.</p> <p>A review of the nurse's notes, dated 06/02/12, revealed no documented evidence the facility notified the physician regarding a change in Resident #11's status related to the catheter, resident discomfort, or for need to alter treatment with an order to irrigate the bladder.</p> <p>A review of the facility's Investigation Report, dated 06/08/12, revealed Resident #11's family reported to the Assistant Director of Nursing (ADON), on 06/05/12, that they reported to RN #3 about Resident #11's complaint of pressure and his/her face being flush. There was no evidence in the facility's Investigation Report that the physician had been notified related to the</p>	F 157			

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F 157	Continued From page 8 catheter, resident discomfort, for need to alter treatment with an order to irrigate the bladder. The was no evidence the facility had obtained a physician's order for the bladder irrigation.  An interview with the ADON, on 08/03/12 at 4:35 PM, revealed she reviewed Resident #11's chart and found no documentation in the nurse's notes, on 06/02/12, related to concerns with the resident's catheter or interventions implemented. She further stated there was no physician's order to irrigate the resident's catheter. She stated the facility's policy required a physician's order to irrigate a urinary catheter. She stated she expected the staff to call the physician prior to irrigating a urinary catheter.  An interview with the Director of Nursing (DON), on 08/02/12 at 1:55 PM and 6:03 PM, revealed she was unable to recall if RN #3 notified the physician of a change in Resident #11's status related to his/her catheter, because the nurse did not document anything in the nurse's notes. She stated there should have been an order to irrigate the urinary catheter. She further stated she expected the staff to notify the physician of a change in the resident's status.	F 157			
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224	<i>F 224 It is the policy of Cal Turner Rehab and Specialty Care and routine practice to implement written policies and procedural guidelines that prohibit mistreatment, neglect, and misappropriation of resident property and abuse of residents.</i>	08/23/12	

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F 224	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's investigation, and review of the facility's policy/procedure, it was determined the facility failed to prohibit neglect of residents for one resident (#11), in the selected sample of twenty-two (22) residents. On 06/02/12 at approximately 5:15 PM, Resident #11 was observed with a red face, eyes watering and stating "I am trying to pee." Family Member (FM) #1 reported to Registered Nurse (RN) #3, on 06/02/12, that Resident #11 was complaining of pressure related to the urinary catheter and his/her face was flushed. RN #3 then adjusted the catheter tubing. For approximately one (1) hour the resident continued to be uncomfortable, and the family requested RN #3 to relieve the resident's discomfort. FM #2, at approximately 6:45 PM, observed Resident #11 with tears rolling down his/her face. FM #2 requested RN #3 to care for Resident #11's discomfort. RN #3 delegated the staff to assist Resident #11 to lay down which still had not been initiated. Licensed Practical Nurse (LPN) #2 flushed the resident's urinary catheter and reported the resident felt better. FM #1 stated the catheter bag had to be emptied twice. The facility's investigation failed to identify the deprivation by a care taker of services which resulted in Resident #11 experiencing discomfort, face flushed and crying for over an hour.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Suspected Abuse or Neglect," last revision</p>	F 224	<p>Continued from page 9</p> <ol style="list-style-type: none"> <li>1. Resident #11 was evaluated on 6/5/12 by the ADON with no distress, depression, or concerns voiced or noted.</li> <li>2. The Suspected Abuse or Neglect policy was reviewed by the DON, ADON, Administrator, and EVP on 8/3/12 to ensure that all residents are protected from abuse or neglect and no other residents were affected. The DON and ADON conducted a review and rounding of all residents on 8/8/12 to determine if any resident had potentially been exposed to any neglect that had not been reported and investigated. No other residents were found.</li> <li>3. All facility staff received in-service training and review of the Suspected Abuse or Neglect policy and procedural guidelines for Cal Turner Rehab and Specialty Care to identify and report any suspected neglect or abuse. The training was provided by the clinical educator and completed by 8/22/12. In addition, all new employees will receive training by the clinical educator on suspected abuse or neglect during unit specific orientation prior to assuming any direct care assignments. All staff will demonstrate on-going annual competency for suspected abuse and neglect identification and reporting to the Clinical Educator. Any staff failing to demonstrate competency will be re-educated immediately by the Clinical Educator prior to returning to work.</li> </ol>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/03/2012
NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164	
(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 224	<p>Continued From page 10</p> <p>03/10, revealed documentation to define neglect as "the deprivation by a caretaker of services, which are necessary to maintain the health and welfare of an adult."</p> <p>A record review revealed the facility admitted Resident #11 on 05/29/10 with diagnoses to include Renal Failure, Alzheimer's Disease, and Cerebral Vascular Accident. A review of physician's orders, dated 07/01/12, revealed "change foley catheter every thirty (30) days." Review of the record revealed no additional orders related to the resident's catheter. A record review revealed no evidence of an assessment for Resident #11 on 06/02/12 related to the catheter, resident discomfort, or for need to alter treatment with an order to irrigate the bladder.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 06/05/12, revealed the facility identified the resident to have a Brief Interview for Mental Status (BIMS) score of five (5), which meant the resident was severely cognitively impaired. The resident required extensive assistance of two staff members for bed mobility, transfer, personal hygiene, and toileting needs. The resident had an indwelling catheter and was frequently incontinent of bowel.</p> <p>During initial tour of the facility, on 07/31/12 at 4:10 PM, a family member voiced concerns with the care Resident #11 received related to his/her catheter. She further stated the family had requested that RN #3 no longer be allowed to provide care to Resident #11. An observation revealed Resident #11 had an indwelling catheter with a dignity bag.</p>	F 224	<p>Continued from page 10</p> <p>4. The Social Service Director will provide ongoing education to the residents, guardians, and interested family members weekly for 6 months to ensure that any issues have been reported and investigated as required. The ADON, DON, Administrator, and Risk Management will review all reported incidents. The DON is responsible to ensure staff's compliance with policy and procedural guidelines.</p> <p>5. Corrective actions were completed by 8/23/12.</p>	

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F 224	<p>Continued From page 11</p> <p>An interview with FM #1, on 08/02/12 at 7:35 PM, revealed she arrived at the facility on 06/02/12 at approximately 5:15 PM. She stated Resident #11 was in the dining room, his/her face was red and eyes were watering. She stated the resident kept repeating, "I am trying to pee." She requested a Certified Nurse Aide (CNA) to ask the resident's nurse to come to the dining room. She waited for approximately fifteen (15) minutes, and all the time the resident was straining and appearing to be in discomfort. She stated RN #3 came to the dining room and stated the catheter might be twisted. The family member stated the nurse looked up the resident's pant leg to about his/her knee, and the nurse did not appear to untwist the catheter. She stated that the nurse said his/her bag was full and just put it back in the dignity bag. The family member stated she then texted FM #2, and made her aware of Resident #11's condition. FM #2 stated she was on the way to the facility. FM #1 stated she pushed Resident #11 from the dining room back to the lobby at the nurse's station at around 6:00 PM. She stated the resident had tears rolling down his/her face and was still making grunting sounds. She stated she approached the nurses's desk and advised RN #3 the resident was still hurting. She said the nurse just sat there, but stated she would check the resident when they put him/her to bed. The family member stated the nurse did not tell the CNAs to put the resident to bed. FM #1 stated FM #2 arrived at the facility and advised RN #3 we were going to take Resident #11 to the Emergency Room (ER). FM #1 stated there was another nurse at the nurse's station. She motioned for us to take the resident to his/her room. The nurse and another staff member took the resident to the bathroom and emptied the</p>	F 224		
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F 224	<p>Continued From page 12</p> <p>catheter bag and irrigated the catheter. FM #1 stated she heard the resident say, "Oh" like he/she was relieved. FM #1 stated after the nurse irrigated the catheter, the resident filled the bag up again, and then the resident was fine.</p> <p>An interview with FM #2, on 08/02/12 at 6:15 PM, revealed after reviewing her text messages, she had received a text message from FM #1, on 06/02/12 at 5:47 PM and 6:16 PM, stating Resident #1 was "having a hard time peeing and that his/her face was real red." FM #2 stated she texted FM #1 to have the nurse check his/her catheter. She stated FM #1 texted back that the nurse said she would check the resident when they put him/her to bed. FM #2 stated she arrived at the facility at approximately 6:45 PM. She stated she saw FM #1 sitting on the couch and Resident #11 had "tears" rolling down his/her face. She stated RN #3 was sitting at the nurse's station. FM #2 stated FM #1 told her she had made the nurse aware of the resident's condition in the dining room, and the nurse told her the catheter was not in a kink, the bag was full, and she would check it later. FM #2 stated FM #1 told her after returning to the nurse's station, she had reported to the nurse another two (2) to three (3) times that Resident #11 was "trying to pee." FM #2 stated RN #3 advised her the catheter had been changed recently. FM #2 stated she told the nurse she did not care. "There is a problem now." FM #2 stated the nurse did not say anything and did not move from her seat. FM #2 stated a CNA approached her and asked if she could help. FM #2 stated she told the CNA, "I have already told the nurse. She is aware of the problem. We are going to the ER." FM #2 stated LPN #2 stated "Just take the resident to his/her</p>	F 224		

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F 224	<p>Continued From page 13</p> <p>room." She stated the LPN got the supplies and stated "I do not know why RN #3 did not flush the catheter. LPN #2 stated she had the resident last week, and he/she had the same problem, and all the catheter needed was to be flushed. FM #2 stated LPN #2 took Resident #11 to the bathroom. She stated when the resident came out of the bathroom, he/she was totally different. FM #2 stated she asked the resident if he/she felt better, and the resident stated "Oh, yes." FM #2 stated the resident was not red any more. She stated she reported the incident to the Assistant Director of Nursing (ADON) on 06/05/12. She stated she told the ADON what happened over the weekend with RN #3 was unacceptable. She stated she advised the ADON the family did not want RN #3 to provide care for Resident #11 again.</p> <p>An interview with CNA #7, on 08/03/12 at 10:30 AM and 2:15 PM, revealed he was working the weekend of 06/02/12 to 06/03/12. He stated at approximately 6:30 PM, a family member of Resident #11 stopped him in the hallway and asked if he would put the resident in bed. He stated he recalled Resident #11's complaint about his/her catheter, because his/her catheter had to be adjusted more often than others. He stated he thought LPN #2 flushed his/her catheter. He stated the resident did not appear to be in distress when he laid him/her in bed. He further stated the administrative staff had not interviewed him about the incident.</p> <p>An interview with LPN #2, on 08/03/12 at 8:55 AM, revealed she recalled the incident related to Resident #11's catheter. She stated around 6:00 PM, a family member of Resident #11 asked her</p>	F 224		
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F 224	Continued From page 14 who the resident's nurse was, because she thought the resident was uncomfortable and needed to go to the bathroom. LPN #2 stated she told the family member the resident's nurse was RN #3. She stated she told RN #3 the family wanted to speak to her. She stated she did not hear the conversation between RN #3 and the family member. LPN #2 stated the family member took the resident to the dining room. LPN #2 stated she was in and out of the dining room during the dinner meal. She further stated she recalled the family member saying something about the resident still being uncomfortable. LPN #2 stated the resident's face was flushed, and he/she was restless in his/her wheel chair. She stated RN #3 told her that she had checked the resident's catheter to see if it was kinked and would lay the resident down after dinner and check the catheter to see if there was a problem. LPN #2 stated Resident #11 sat through dinner looking uncomfortable. At approximately 7:00 PM, the family member and Resident #11 were in the hallway near the resident's room. She stated the resident looked about the same. His/her face was flushed. She stated RN #3 was sitting at the nurse's station with the night shift nurse. She stated she asked two (2) CNAs, but did not recall who the CNAs were, to take Resident #11 to the bathroom. She stated she flushed the catheter. It started flowing and the resident appeared to be relieved right away. LPN #2 stated her definition of neglect was not giving a resident the care they needed. She further stated she did not think a resident should be left in that condition for over an hour. A review of the "Intake and Output Record," for 06/12, revealed there was no urine output recorded for 06/02/12 evening shift, after Resident #11's catheter was irrigated.	F 224		

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F 224	Continued From page 15  An interview with RN #3, on 08/02/12 at 4:50 PM, revealed she was the charge nurse for Resident #11 on 06/02/12. She stated Resident #11 was in the dining room and a family member was present. RN #3 stated she was in the dining room feeding another resident. She stated the family member told her Resident #11 needed to "pee." She stated the tubing was kinked. She unkinked the tubing, and the catheter started to flow. RN #3 stated the resident did not appear to be in any distress or pain. However, she stated it appeared there was some relief, because the resident was not saying he/she needed to "pee." She stated twenty (20) to thirty (30) minutes later, the family member brought the resident back to the lobby area at the nurse's station. RN #3 stated another family member arrived at the facility. She stated this family member asked her when was the last time the catheter was changed and when had the resident had a urinalysis. She stated she reviewed the chart. She further stated because the resident was still having discomfort she thought she would have to change the catheter related to sediment in the resident's urine. She stated she told FM #2 she would have the CNAs lay the resident down. RN #3 stated she had been unsuccessful in the past with irrigating the catheter, and was just going to change the catheter. She stated she went to get the CNAs and asked them to lay the resident down. She further stated she realized the family was getting upset with her, and went a second time to get the CNAs. She stated she saw LPN #2 walking to the resident's room with the family members. She stated LPN #2 had the resident sit on the toilet and she irrigated his catheter. She stated she thought that was the end of it until	F 224		

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F 224	<p>Continued From page 16</p> <p>the DON, approximately ten (10) days later, met with her about the care she had provided to Resident #11 and the family was upset. She stated she was told the family did not want her to provide care to Resident #11 in the future.</p> <p>A review of the facility's Investigation Report, dated 06/08/12, and the Counseling Record Performance Improvement for RN #3, dated 07/06/12, revealed Resident #11's family reported to ADON, on 06/05/12, they had reported to RN #3 about Resident #11's complaint of pressure and his/her face being flushed. It was documented in the report that RN #3 responded to the resident and adjusted the catheter to ensure flow of urine to the bag. She reviewed the chart and the catheter had been recently changed. The family member approached RN #3 again, and stated something else about the resident feeling uncomfortable. RN #3 agreed to lay Resident #11 down and assess the resident and delegated staff to lay Resident #11 down. LPN #2 flushed the resident's catheter and the resident reported feeling better. The report revealed Resident #11 was unable to recall the event. The report revealed the facility interviewed only RN #3 and LPN #2 as there was no evidence the facility interviewed any other staff. The facility investigation concluded there was no indication that neglect occurred; however, a review of the Counseling Record Performance Improvement for RN #3 revealed "the Director of Nursing (DON) met with RN #3 on 06/08/12, to discuss the 06/02/12 incident as a family member reported RN #3 did not properly care for Resident #11. The family member was extremely upset and reported she told RN #3 the resident was uncomfortable because his/her catheter was not</p>	F 224		

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F 224	Continued From page 17 working properly. The document revealed family stated RN #3 told them 'when we put him/her to bed we will flush his/her catheter.' Approximately one (1) hour later the family addressed RN #3 as the resident continues to be uncomfortable and asked RN #3 again to take care of the resident to relieve his/her discomfort. LPN #2 reported the resident did appear to be uncomfortable, the resident's face was flushed and he/she was squirming in his/her wheelchair due to discomfort and took the resident to the bathroom and flushed the catheter. A large amount of urine was released, and the resident had immediate relief from his/her discomfort. "This made the family member extremely angry because she realized the resident did not need to be placed in bed as you recommended, but his/her discomfort could have been alleviated immediately by flushing the catheter. The family member stated you had allowed the resident to be uncomfortable for an extended period of time."  An interview with the ADON, on 08/03/12 at 4:35 PM, revealed FM #2 reported to her sometime in June, after a weekend shift, that she was upset with the care Resident #11 received from RN #3. FM #2 told her that another family member had called her and said she thought Resident #11 was uncomfortable and wanted the nurse to do something about the resident's catheter, but the nurse would not pay any attention to her. The ADON stated FM #2 told her the nurse was just sitting at the desk and that LPN #2 assisted by irrigating the catheter, and the resident got instant relief. FM #2 asked "Why couldn't RN #3 have done that?" The ADON stated she did not consider this to be an allegation of neglect. She stated she considered it to be a customer service	F 224		

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F 224	<p>Continued From page 18</p> <p>issue. She stated it would have been neglect, if RN #3 had not responded. She further stated she had not reported the allegation to the State Agencies, and she had not interviewed any CNAs on duty at the time of the incident to determine what they had heard or seen.</p> <p>An interview with the DON, on 08/02/12 at 1:55 PM and on 08/03/12 at 6:03 PM, respectively, revealed the family reported the incident related to RN #3 and Resident #11's catheter to the ADON, on 06/05/12, on the evening shift. The family member stated she had thought about it and was aggravated. She stated the ADON then reported the incident to her. The DON stated the family member told the ADON she had reported to RN #3 that Resident #11 was uncomfortable in the dining room. The family member stated she went back to RN #3 approximately one (1) hour later and reported the resident was still uncomfortable. The family member told the DON that RN #3 told her she would get the CNAs to lay the resident down, because his/her catheter may need to be flushed. The DON stated the family member was upset because RN #3 was giving report. The family member reported that LPN #2 came and flushed the resident's catheter. The DON revealed once the catheter was flushed the resident was okay. The DON stated that RN #3 had reported to her this is an ongoing problem with Resident #11's catheter needing to be repositioned or changed. The DON further stated she did not know if RN #3 notified the physician related to the change in Resident #11's condition or the need to irrigate the catheter, because there was no documentation in the nurse's notes. The DON stated she, the ADON and Human Resources (HR) staff interviewed RN #3 after</p>	F 224		
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F 224	Continued From page 19 being made aware of the incident. The DON stated that RN #3 stated she did go to the dining room and adjusted the resident's cathetar. She stated RN #3 reported that the resident then felt fine. The DON stated she and HR staff had a counseling session with RN #3 on 07/06/12 and advised her she was being removed from caring for Resident #11 per the family's request. The DON stated RN #3 had prior counseling sessions on 11/01/10, 11/25/11 and 11/26/11 and a below standard performance evaluation, making this her "final warning period counseling." The DON stated after she completed the investigation, she reported to the Administrator that she did not feel like RN #3 had neglected the resident and had responded appropriately to the resident's needs. She stated she fell like the family thought that RN #3 had not responded quick enough to their concerns. The DON further stated she did not interview any CNAs during her investigation of the incident, and she had not reported it to the State Agencies, because she had not considered it neglect.  An interview with the Administrator, on 08/02/12 at 10:45 AM, revealed he did not think this incident was an allegation of neglect, therefore, they did not investigate or report it. He stated he just heard the family was upset not that they reported it as an allegation of neglect. He stated he would consider it neglect if care was not provided, but care was provided.	F 224		
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226	<i>F 226 It is the policy and routine practice of Cal Turner Rehab and Specialty Care to promote the care, and maintain or enhance the resident's dignity and respect. It is the policy of Cal Turner Rehab and Specialty Care and routine practice to implement written policies and procedural guidelines that prahibit mistreatment, neglect, and misappropriation of resident property and abuse of residents and properly investigates any suspected obuse or neglect.</i>	08/23/12

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F 226	Continued From page 20 and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy/procedure and the Final Investigation Report, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit neglect of residents for one resident (#11), in the selected sample of twenty-two (22) residents. The facility failed to implement the Suspected Abuse or Neglect policy/procedure as evidenced by failure to identify an allegation made by Resident #11's family as neglect per their policy's neglect definition. This failure prevented the facility from notifying the State agencies of the allegation. Furthermore, the facility failed to conduct a thorough investigation, having only interviewed two (2) staff regarding the incident. Also, due to the failure of identifying the allegation as neglect, this prevented the facility from reporting the investigation results within five (5) days. On 06/05/12, Resident #11's family reported an allegation of neglect to the Assistant Director of Nursing (ADON), alleging that the facility failed to provide timely care and services to Resident #11 related to catheter care. On 06/02/12, Family Member (FM) #1 and FM #2 alleged staff delayed, for approximately one (1) hour, providing necessary catheter care to Resident #11 who was observably uncomfortable, squirming in the wheelchair, expressing "I'm trying to pee," eyes watering with tears rolling down his/her face. Once staff provided care it was identified the	F 226	Continued from page 20  1. Resident #11 was evaluated on 6/5/12 by the ADON with no distress, depression, or concerns voiced or noted. Investigation was completed on 6/8/12 by the DON and reported to the Administrator. RN#3 did not have contact with residents during the duration of the investigation of concern 6/5/12 through 6/8/12. 2. The DON, ADON, Administrator, and EVP reviewed the Suspected Abuse or neglect policy on 8/3/12 specifically to ensure that the report and investigative protocol was in accordance with the law. The policy directs facility practice and the practice of reporting abuse and/or neglect at Cal Turner Rehab and Specialty Care. The DON and ADON conducted a review and rounding of all residents on 8/8/12 to determine if any resident had potentially been exposed to any neglect that had not been reported and investigated. No other residents were found. 3. All facility staff received in service training and review of the Suspected Abuse or Neglect policy and procedural guidelines for Cal Turner Rehab and Specialty Care to identify and report any suspected neglect or abuse. The training for all staff was facilitated by the Clinical Educator and completed by 8/22/12. In addition, all new employees will receive training by the clinical educator on suspected abuse or neglect during unit specific orientation prior to assuming any direct care assignments. All new staff will demonstrate on-going competency for suspected abuse and neglect identification and reporting prior to starting their first scheduled shift. The clinical educator will ensure all existing staff demonstrate competency annually on identifying and reporting suspected abuse or neglect.	

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F 226	Continued From page 21 resident's catheter required flushing, the catheter bag had to be emptied twice. Upon receipt of care, the resident's discomfort was relieved. The facility failed to identify the allegation as neglect and their investigation failed to determine neglect occurred.  Refer to F224  Findings include:  A review of the facility's policy/procedure, "Suspected Abuse or Neglect," last revised 03/10, revealed "It is the policy of this facility to report and thoroughly investigate known or suspected resident abuse, neglect, or exploitation in accordance with applicable law. Investigation of suspected abuse/neglect is aimed at determining if abuse or neglect have occurred, the extent of abuse and/or neglect, the causative factors, and the interventions to prevent further injury. The results of all investigations will be reported to the Department of Community Based Services and the regional office of the Division of Licensing and Regulation within five (5) working days of the incident. Neglect-the deprivation by a caretaker of services, which are necessary to maintain the health and welfare of an adult."  A record review revealed the facility admitted Resident #11 on 05/29/10 with diagnoses to include Renal Failure, Alzheimer's Disease and Cerebral Vascular Accident. A review of the quarterly Minimum Data Set (MDS), dated 06/05/12, revealed the facility identified the resident with a Brief Interview for Mental Status (BIMS) score of five (5). The resident had an indwelling catheter and was frequently incontinent	F 226	Continued from page 21  4. Beginning 8/22/12, all staff will initiate an electronic report for any suspected or reported concerns regarding neglect or abuse. These reports will be reviewed upon completion by the ADON, DON, Administrator, Risk Management, and the Quality Resource Management. The report will include documentation regarding interviews of all staff involved and notification of DON or Administrator on call. The report will be stored and transmitted for review electronically by the Administrator, DON, Risk Management and the Quality Resource Management officer. The Social Services Director will provide education to the residents, guardians, and interested family members weekly for 6 months to ensure that any issues have been reported and investigated as required. The ADON, DON, Administrator, and Risk Management will review all reported incidents. The DON is responsible to ensure staff's compliance with policy and procedural guidelines. 5. Corrective actions were completed by 8/23/12.	

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F 226	<p>Continued From page 22 of bowel.</p> <p>During initial tour of the facility, on 07/31/12 at 4:10 PM, a family member voiced concerns with the care Resident #11 received related to his/her catheter. She further stated the family had requested Registered Nurse (RN) #3 no longer be allowed to provide care to Resident #11. An observation revealed Resident #11 had a urinary catheter with a dignity bag. Interview with FM #1 and FM #2, on 08/02/12 at 7:35 PM and 6:15 PM, respectively, revealed they filed a complaint to the ADON alleging neglect, because the facility did not respond timely to the needs of Resident #11's discomfort related to his/her catheter care. The family members revealed they observed Resident #11, on 06/02/12, stating "I'm trying to pee," having watery eyes with tears rolling down his/her face. They stated FM #1 requested care for Resident #11 to Licensed Practical Nurse (LPN) #2 and RN #3. While RN #3 checked for a kink in the catheter, the action did not correct the problem, and Resident #11 continued to be in discomfort for over an hour before LPN #2 finally flushed and emptied the catheter bag twice.</p> <p>An interview with the ADON, on 08/03/12 at 4:35 PM, revealed she had received a complaint from a family member of Resident #11, on 06/05/12. The ADON stated the family member advised her she had reported to RN #3 concerns with the resident's indwelling catheter related to the resident feeling uncomfortable and his/her face being flushed. The ADON stated the family reported that this continued for approximately an hour with RN #3 just sitting at the desk. The ADON stated the family member told her that LPN #2 came to assist the resident, irrigated the</p>	F 226			

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F 226	<p>Continued From page 23</p> <p>indwelling catheter, with the resident getting instant relief. She stated the family member wanted to know why RN #3 had not done that. The ADON stated she did not consider this to be an allegation of neglect. She stated she considered it to be a customer service issue. She stated it would have been neglect, if RN #3 did not respond. She further stated she had not reported the allegation to the State Agencies.</p> <p>An interview with the Director of Nursing (DON), on 08/02/12 at 1:55 PM, and on 08/03/12 at 6:03 PM, revealed that she did not report it to the State Agencies, because she had not considered it an allegation of neglect.</p> <p>A review of the facility's Investigation Report, dated 06/08/12, revealed Resident #11's family reported to the ADON, on 06/05/12, they had reported to RN #3 about Resident #11's complaint of pressure and his/her face being flushed. Review of the report revealed the facility detailed the allegation did not meet the definition of neglect. Furthermore, the document detailed notification to State Agencies was "N/A" (not applicable). Review of the facility's policy defines neglect as "the deprivation by a caretaker of services, which are necessary to maintain the health and welfare of an adult." Review of the investigation revealed the facility interviewed only LPN #2 and RN #3. There was no evidence they attempted to interview both family members, other staff working at the time of the incident, or other residents of the facility. Interview with the ADON revealed she had not interviewed any Certified Nurse Aides (CNAs) on duty at the time of the incident to determine what they had heard or observed. Interview with the DON revealed</p>	F 226			

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F 226	Continued From page 24 she did not interview any CNAs during her investigation of the incident. It was documented in the report that RN #3 responded to the resident and adjusted the catheter to ensure flow of urine to the bag. She reviewed the chart and the catheter had been recently changed. The report further revealed the family member approached RN #3 again, and stated something else about the resident feeling uncomfortable. RN #3 agreed to lay Resident #11 down and assess the resident. The report further revealed RN #3 instructed the staff to lay Resident #11 down, and LPN #2 flushed the resident's catheter and he/she reported feeling better. The report revealed Resident #11 was unable to recall the event. The report revealed RN #3 and LPN #2 were interviewed. There was no evidence the facility interviewed any other staff, the family members or other residents. The facility investigation concluded that staff responded appropriately and follow up was appropriate and timely; however, there was no evidence of time included in the document and no interviews with the family which prevented them from accurately determining if neglect had occurred. Furthermore, while the facility's investigation determined no concerns with staff's response to the family members concern for Resident #11's discomfort, interview with the DON, on 08/02/12 at 1:55 PM, revealed the facility counseled RN #3 on 07/06/12 detailing the family's reported 06/02/12 incident involving Resident #11's catheter care. The counseling report detailed, the family felt Resident #11's "discomfort could have been alleviated immediately by flushing the catheter. The family stated you had allowed the resident to be uncomfortable for an extended period of time." The DON removed RN #3 from	F 226		

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F 226	Continued From page 25 caring for Resident #11. Additionally, while the facility determined neglect did not occur, interview with LPN #2, on 08/03/12 at 8:55 AM, revealed neglect was not giving a resident the care they needed. She stated she did not think a resident should be left in that condition for over an hour.  An interview with the DON, on 08/02/12 at 1:55 PM, revealed after she completed the investigation, she reported to the Administrator that she did not feel like RN #3 had neglected the resident and had responded appropriately to the resident's needs. She stated she felt like the family thought that RN #3 had not responded quick enough to their concerns.  An interview with the Administrator, on 08/02/12 at 10:45 AM, revealed the facility did not consider the complaint an allegation of neglect, and stated it was not reported to the State Agencies.	F 226		
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 review of facility policies and procedures, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The facility failed to provide housekeeping and maintenance services to ensure ice maker chutes, sink areas, ceiling vents, clothes	F 253	F 253 The facility provides housekeeping and maintenance services necessary to maintain sanitary, orderly, and comfortable interiors.	08/23/12

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F 253	<p>Continued From page 26</p> <p>washers, light cords and faucets were sanitary or in good repair.</p> <p>Findings include:</p> <p>A review of the facility's Housekeeping policy and procedure, "Attendant Pink," undated, revealed the housekeeping personnel would complete an engineering work order when a room repair was needed.</p> <p>A review of the facility's policy and procedure, "General Cleaning Procedures," undated, revealed sinks and fixtures would be cleaned with germicidal cleaner.</p> <p>1. Observations during the initial tour, on 07/31/12 at 10:45 AM, revealed the following:</p> <p>a) In room B-02, both over the bed lights were missing the cords used to turn the lights on.</p> <p>b) The sink faucet was leaking in residents' room B-03.</p> <p>c) There was a large gash to the wall underneath the sharps container in the bathroom of room B-13.</p> <p>d) There were large areas of scrapings to the dry wall near the headboard in room B-14, bed one.</p> <p>e) There was a blackened area on the floor near the right side of the bed in room B-25, bed one.</p> <p>Interview with "B" Hall Registered Nurse (RN) #7, on 08/02/12 at 1:45 PM, revealed the process for maintenance repair on the unit was to complete a</p>	F 253	<p>Continued from page 26</p> <p>1. On 07/31/12, residents in rooms B-02, B-03, B-13, B-14, and B-25 were impacted. On 08/02/12, the Facilities Manager assigned the following:</p> <p>a. Repairs for Engineering staff to complete</p> <p>i. Replace missing cords for over bed lights in room B-02- completed 08/02/12</p> <p>ii. Repair leaking faucet in room B-03- completed 08/02/12</p> <p>iii. Repair dry wall underneath sharps container in the bathroom of room B-13 and behind head board of room B-14- completed 08/02/12</p> <p>iv. Replaced caulking to back splash and counter top areas behind the sink in the C Hall Residents' Day/Activities area - completed 08/02/12</p> <p>v. Replaced the rubber flange/gasket around the interior side of the washing machine doors- completed 08/22/12</p> <p>vi. Cleaned the interior of the ice dispenser chute on the ice maker in the B Hall Nourishment room- completed 08/02/12</p> <p>b. Cleaning for Environmental staff to complete</p> <p>i. Cleaned blackened scuff marks on floor in room B-25- completed 08/02/12</p> <p>ii. Cleaned back splash and counter top behind the sink in the C Hall Residents' Day/Activities area- completed 08/02/12</p> <p>iii. Cleaned ceiling air vents and two return air vents of the television areas on C Hall- completed 08/02/12</p>	

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F 253	<p>Continued From page 27</p> <p>work order describing the room number and the problem. She stated any staff person was able to complete the work order.</p> <p>Interview with the Director of Nursing (DON), on 08/02/12 at 3:50 PM, revealed residents pull hard on the over bed light cords and the cords break frequently. She stated she made rounds on Wednesday mornings and made a list of repairs to be done which was passed on to engineering.</p> <p>Interview with the Facility Manager, on 08/01/12 at 2:25 PM, revealed work orders were filled out by staff when maintenance issues were identified and placed in the maintenance box on each unit. He stated he collected the work orders every morning and put into computer system. He stated he also conducted rounds throughout the building every Monday and Wednesday to identify any maintenance issues. He revealed he had no work orders for the above concerns and had not identified them on rounds yesterday.</p> <p>2. Observation during General Observations, on 08/01/12 at 10:20 AM, revealed the following:</p> <p>a) The back splash and counter top behind the sink in the "C" Hall Residents' Day/Activities area were wet with standing water, discolored with soap residue, and had a black discoloration in the caulking.</p> <p>b) There was a heavy layer of black dust and lint covering the ceiling air vent and the two (2) return air vents in the ceiling of the television area on C hall.</p> <p>c) The three front loading washing machines in</p>	F 253	<p>Continued from page 27</p> <p>2. On 08/02/12, Engineering staff and Environmental Services staff inspected remaining areas and residents' rooms. No other residents were impacted.</p> <p>3. As of 08/02/12, the Facilities Manager developed and implemented the following:</p> <p>a. Use of a log sheet for Engineering staff to complete when doing room inspections monthly.</p> <p>b. Reminded Environmental Services staff to complete and submit their room inspection log sheets daily.</p> <p>c. Increased the frequency for the ice machine chute inspections and cleaning to a monthly schedule</p> <p>4. As of 08/02/12, the Facilities Manager will monitor the Environmental Services and Engineering room inspection log sheets quarterly. The Administrator, Facilities Manager, and DON will make weekly rounds for the next 12 months to identify and implement ongoing repair and cleaning needs. Identified needs will be reported to the Facilities Manager who will ensure completion of work by assigning work orders to Engineering Staff. The Facilities Manager will monitor the completion of work orders monthly using the Facilities software program.</p> <p>5. All corrective actions were completed by 08/23/12</p>	

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F 253	<p>Continued From page 28</p> <p>the laundry room had a moist, black substance along the rubber flange/gasket around the interior side of the washing machine doors. The substance was visible through the clear glass door.</p> <p>d) The interior of the ice dispenser chute on the ice maker in the "B" Hall Nourishment room was caked with dark colored residue.</p> <p>Interview with the Facility's Manager, on 08/02/12 at 1:45 PM and 2:40 PM, and on 08/03/12 at 11:00 AM, revealed he was not aware of the residue in the ice maker chutes and stated the current quarterly preventative maintenance schedule was the manufacturer's recommendation for cleaning and servicing the machine. He stated what he saw was not acceptable and related it to the "hard" water in the facility. He stated the current preventative maintenance schedule for cleaning the ice dispensers was quarterly. Review of the Preventative Maintenance work order, dated as completed on 06/06/12, revealed the procedure check list did not include the ice dispensing chute. The work order showed the current schedule for cleaning the ice dispensers as every three months. Further interview revealed he was responsible for the housekeeping department and housekeeping was responsible for cleaning the sink areas in the Activities areas. He stated he had instructed housekeeping staff to notify him when mold was found. The staff should use a 50:50 bleach solution for cleaning. If it was a large amount of mold, the maintenance department would remove and replace the caulk. He was not aware of the black discoloration in the caulking behind the sink in the "C" Hall Residents'</p>	F 253			

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(X4) IO 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 29 Activity/ Day room. He also revealed the housekeeping staff was responsible for cleaning the washing machines and had been instructed to use a 50:50 bleach solution for cleaning and to make sure the gasket was dry.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure, it was determined the facility failed to develop comprehensive care plans for three residents (#1, #7 and #18), in the selected sample of 22 residents, based on the assessments completed	F 279	F 279 It is the policy and routine practice of Cal Turner Rehab and Specialty Care to develop a comprehensive care plan for each resident.  1. Residents #1, #7, and #18 have been assessed according to RAI guidelines and facility policy with care plans developed that include all areas triggered by Care Area Assessment. This was completed by MDS Coordinator on 8/3/12. 2. A complete comprehensive chart audit of all residents was performed by the MDS Coordinator on 8/21/12 with interventions initiated for each resident on 8/21/12 and the findings reported to the DON 8/21/12. 3. The MDS Coordinator educated the interdisciplinary team (DON, ADON, MDS Coordinator, Dietitian, Social Worker, and Activities Coordinator) on 8/21/12 to include an individualized resident care plan being created on 8/21/12 for every triggered Care Area Assessment (CAA). Record of education was sent to Clinical Educator and D.O.N on 8/21/12. 4. The MDS Coordinator will audit all CAAs quarterly to be sure each is addressed in the individualized resident care plan and the findings reported to the DON at the end of the quarterly review. 5. All corrective actions completed 8/23/12.	08/23/12

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F 279	<p>Continued From page 30</p> <p>by the facility of each resident. The facility failed to develop a care plan related to blindness for Resident #1; urinary incontinence, pain and behavioral symptoms for Resident #7; and delirium and behavioral symptoms for Resident #18.</p> <p>Findings include:</p> <p>A review of the facility's Care Plan policy, revised 07/12, revealed that the objectives are to provide consistent, continuous care and comprehensive care; to provide care that is interdisciplinary; to plan for continuity of care for the resident upon discharge. Furthermore, the policy revealed that the care to be provided is based on established standards of resident care that reflect the stated diagnosis(es) and is identified by the Registered Nurse at the conclusion to the admission assessment, within 24 hours of the resident's arrival. In addition, an interim care plan will be initiated on all residents, upon admission to the facility. All residents will be assessed by an RN and LPN and an interim care plan will be devised from the resident assessment, interview, transfer orders, history and physical, and transfer sheet sent with the resident. The interim care plan will be completed within 24 hours of admission of admission and will be implemented until the comprehensive care plan is developed by day 21. Expected resident outcomes and resident care orders will be documented on all residents within 21 days of admission. Also, the plan of care shall be reviewed by an interdisciplinary team quarterly and shall be assessed as appropriate based on evaluation of the resident's progress toward the expected outcome. The LPN contributes information and feedback for evaluation and</p>	F 279			

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F 279	<p>Continued From page 31 revision.</p> <p>1. A record review revealed the facility admitted Resident #1 on 06/28/12 with diagnosis to include Cardiovascular Accident (CVA).</p> <p>A review of the Initial Nursing Assessment, dated 06/28/12, revealed the facility assessed Resident #1 as blind in the left eye.</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 07/05/12, revealed the facility assessed Resident #1 was having difficulty seeing the television, reading material of interest, or participating in activities of interest because of vision problems.</p> <p>A review of the Visual Function Care Area Assessment (CAA) Summary, dated 07/05/12, revealed a family member reported Resident #1 had no vision in the left eye since having the CVA several years ago and had some vision in the right eye and could track with his/her eyes. The resident was unable to respond verbally or with head movements to simple vision screening questions. Further review of the CAA revealed the facility was going to proceed with Care Planning for vision.</p> <p>A review of the Comprehensive Care Plan, dated 07/05/12, revealed there was no evidence the facility developed a care plan related to vision and there were no goals or interventions to address Resident #1's blindness. A review of the Certified Nurse Aide (CNA) care plan, undated, revealed Resident #1 was blind in the left eye, but there were no interventions to address the resident's blindness.</p>	F 279		

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F 279	<p>Continued From page 32</p> <p>An interview with Registered Nurse (RN) #1, on 08/02/12 at 11:10 AM, revealed she was unable to provide a Care Plan to address Resident #1's blindness.</p> <p>Interview with the MDS Coordinator, on 08/02/12 at 2:25 PM, and on 08/03/12 at 5:08 PM, revealed Resident #1 was non-ambulatory, dependent for all activities of daily living (ADLs), and did not wear corrective lenses. She stated they utilized nursing judgment as to whether an area should be addressed on the Care Plan depending on the individual resident situation. The MDS Coordinator stated she and the MDS Assistant were responsible to assure that areas triggered on the CAA were addressed in the Comprehensive Care Plan. She revealed the MDS staff manually entered the individual care plan problems.</p> <p>2. A record review revealed the facility admitted Resident #18 on 02/21/11 with diagnosis to include Dementia.</p> <p>A review of the annual MDS assessment, dated 01/10/12, revealed the facility assessed Resident #18 as having metabolic and circulatory heart issues which placed the resident at risk for delirium and verbal behavioral symptoms which significantly disrupted care and the living environment of others.</p> <p>A review of the Comprehensive Care Plan, dated 01/18/12, revealed there was no evidence the facility developed a care plan with goals and interventions to address Resident #18's assessed risk for delirium and verbal behavioral symptoms</p>	F 279			

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F 279	<p>Continued From page 33</p> <p>that significantly disrupted the living environment of others.</p> <p>An interview with the MDS Coordinator, on 08/03/12 at 5:08 PM, revealed she reviewed Resident #18's care plan and there was no care plan to address the resident's risk for delirium and verbal behavioral symptoms. She stated a care plan should have been developed to address the risk for delirium and verbal behavioral symptoms.</p> <p>3. A record review revealed the facility admitted Resident #7 on 05/22/12 with diagnoses to include Altered Mental Status, Lack of Coordination, Dementia with Behaviors, Diabetes, Depression, Anxiety, and Delusional Disorder.</p> <p>A review of a nurse's note, dated 05/23/12 at 7:00 PM revealed Resident #7 was "somewhat argumentative and difficult to redirect."</p> <p>A review of the admission MDS assessment, dated 05/28/12, revealed the facility assessed Resident #7 as having physical, verbal and wandering behavioral symptoms, as occasionally incontinent of bladder and vocal complaints of pain every three to four days.</p> <p>A review of the Comprehensive Care Plans, dated 05/28/12, revealed there was no evidence the facility developed a care plan with goals or interventions to address the management of Resident #7's Behavioral Symptoms.</p> <p>Review of the nurse's note, dated 06/02/12 at 7:00 PM, revealed the resident became extremely agitated and combative with staff. The resident was wanting to go home and was kicking the</p>	F 279		

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F 279	<p>Continued From page 34</p> <p>doors and hitting the glass on the door with a binder. The physician was notified and an order was received to send to the Emergency Room (ER) for evaluation and treatment.</p> <p>A review of the Nursing Summaries, dated 06/03/12, revealed Resident #7 was assessed by the facility as "occasionally incontinent (less than 7 episodes) and as "received as needed (prn) medication for pain."</p> <p>A review of the CAA Summary, dated 06/04/12, revealed the facility determined Resident #7 should be care planned for Urinary Incontinence, Behavioral Symptoms, and Pain.</p> <p>A review of the Comprehensive Care Plans, dated 06/04/12 and 06/05/12, revealed there was no evidence the facility developed a care plan with goals or interventions to address the management of Resident #7's Urinary Incontinence, Behavioral Symptoms, or Pain.</p> <p>A review of the nurse's note, dated 06/06/12 at 9:00 PM, revealed the resident was having an increase in agitation and staff's attempts to redirect the resident were unsuccessful. The resident was combative and was striking out at staff with whatever he/she could reach. He/she was wanting to leave the facility. The resident was wandering the hallways, beating on doors and yelling out. The physician was notified and an order was received to transfer to ER.</p> <p>A review of the nurse's note, dated 06/06/12 at 9:30 PM, revealed the police arrived on the unit to transfer Resident #7 to the ER.</p>	F 279			

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F 279	<p>Continued From page 35</p> <p>There was no evidence of a Comprehensive Care Plan to address the behaviors demonstrated on 06/06/12 by Resident #7.</p> <p>A review of the nurse's note, dated 06/13/12 at 3:40 PM, revealed the resident was continuously pacing in the hallways, going from bed to bed and attempting to leave the facility. The documentation stated "Sit in day area 1:1 when out of bed."</p> <p>There was no evidence of a Comprehensive Care Plan to address the behaviors demonstrated on 06/13/12 by Resident #7.</p> <p>A review of the Nursing Summaries, dated 06/17/12, 07/09/12, and 07/22/12, revealed Resident #7 was assessed by the facility as "occasionally incontinent (less than 7 episodes) and as "received as needed (prn) medication for pain."</p> <p>Review of the Behavior Monitoring logs, dated June and July 2012, revealed Resident #7 demonstrated physical behaviors directed toward others on 06/02/12; verbal behaviors directed toward others, other behaviors not directed toward others, and wandering behaviors on June 2, 12, 16, 17, 21, 22, 25, 26, 27, 28 and 30, and other behaviors not directed toward others, and wandering behaviors on July 1, 2, 3, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30.</p> <p>A review of Medication Administration Records (MAR), dated June and July 2012, revealed Resident #7 received medication for back pain on June 1, 3, 4, 6, 12, 13, 14, 15, 16, 17, 18, 19, 21,</p>	F 279			

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F 279	<p>Continued From page 36</p> <p>22, 23, 25, 26, 27, 28, 29, and 30, and on July 1, 3, 5, 6, 7, 8, 9, 10, 17, 18, 19, 20, 22, 23, 24, 25, 28, 29, and 30.</p> <p>A review of the Nursing Assistant Care Plan, dated August 2012, revealed there were no interventions for the resident's behavior symptoms.</p> <p>Interview with CNA #12, CNA #13 and CNA #15, on 08/01/12 at 9:40 AM and 9:45 AM, and on 08/03/12 at 1:50 PM and 5:00 PM, respectively, revealed Resident #7 was a wanderer and would become agitated. The CNAs revealed Resident #7 was known to need assistance with toileting and had occasional incontinent accidents. Resident #7 was also known to verbalize back pain but would not ask for pain medication.</p> <p>Interview with CNA #10 and CNA #14, on 08/01/12 at 9:55 AM, and on 08/02/12 at 10:50 AM, respectively, revealed Resident #7 had three occurrences of physically aggressive behaviors that mandated he/she be transferred to the hospital.</p> <p>Interview with RN #7, on 08/02/12 at 1:50 PM, revealed the Comprehensive Care Plan process began with the resident's admission to the facility and the licensed nurse's admission assessment for the interim care plan. The MDS coordinator was responsible for the typed care plan and all licensed staff was responsible for revising the care plan when needed. As charge nurse, she expected the staff to change the care plan as the need presented. RN #7 stated the CNA Care Plan was used to provide the CNAs with resident specific information needed to provide care and</p>	F 279			

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F 279	Continued From page 37 the CNA Care Plan information came from the resident's Comprehensive Care Plan. RN #7 stated she was surprised Resident #7 did not have a care plan for behaviors or bladder incontinence and knew Resident #7 took Tramadol for back pain.  Interview with the MDS Coordinator, on 08/02/12 at 2:20 PM, revealed she spoke to each resident and obtained information from each residents' MDS, CAAs and initial nursing assessment to develop the comprehensive care plans for each resident. She revealed the Comprehensive Care Plan for behaviors, bladder incontinence and pain must be included in the medical records.  An interview with the Assistant Director of Nursing (ADON), on 08/03/12 at 5:25 PM, revealed the MDS Coordinator was responsible to transfer information from the MDS assessment to the Comprehensive Care Plans. She stated the nursing staff does not review the care plans to identify any omissions.  An interview with the Director of Nursing (DON), on 08/03/12 at 6:50 PM, revealed that issues that appeared on the CAA should have generated a Care Plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed	F 280	<i>F 280 It is the policy and routine practice of Cal Turner Rehab and Specialty Care to develop a comprehensive care plan for each resident and encourage the resident to participate in the care planning decisions.</i>	08/23/12

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F 280	<p>Continued From page 38</p> <p>within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident's care plan was revised for three (3) residents (#2, #3, and #15), in the selected sample of twenty-two (22) residents, related to incontinence, urinary catheters, lack of interventions for the irrigation of a urinary catheter, and a tube feeding that was discontinued, but still on the care plan.</p> <p>Findings include: Review of the facility's policy for care plans, dated April 1996, and last updated July 2012, revealed "the plan of care shall be reviewed by an interdisciplinary team, quarterly and shall be assessed as appropriate, based on evaluation of the resident's progress toward the expected</p>	F 280	<p>Continued from page 38</p> <ol style="list-style-type: none"> <li>The care plans for Residents #2, #3, and #15 have been revised to reflect their current problems, goals, and interventions by the interdisciplinary team (DON, ADON, MDS Coordinator, Dietitian, Social Worker, and Activities Coordinator) on 8/2/12.</li> <li>The MDS coordinator conducted an audit of all residents with potential to be affected beginning 8/3/12. This was completed by the MDS Coordinator on 8/21/12. No additional residents were identified.</li> <li>The Social Services Manager will invite the resident, family or responsible party, via written letter, 2 weeks prior to their scheduled care conference. If the resident, family or responsible party is unable to attend, they can schedule another time and date. This process started 8/3/12. A copy of the mailed letter will be filed under the Social Services tab in the resident's record. Beginning 8/15/12, the residents will each be personally invited and encouraged to exercise their right to participate in their care planning process on the respective scheduled day for their care conference. The invitation will be documented in the resident's social service notes. In the case that no residents and no family accept the invitation to attend the quarterly care plan meeting, a call will be placed to the family following the meeting by the MDS coordinator, Social Worker, DON, or ADON to determine if there are any issues to address. The care plan of each resident will continue to be reviewed by the team in conjunction with the resident and family at scheduled quarterly care conferences, with a significant change in condition, or upon request.</li> </ol>		

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F 280	<p>Continued From page 39</p> <p>outcome. The Licensed Practical Nurse (LPN) contributes information and feedback for evaluation and revision."</p> <p>1. A record review revealed the facility admitted Resident #2 on 05/29/12 with diagnoses to include Cerebrovascular Accident (CVA), History of Lung Cancer, and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>A review of the Bowel and Bladder Evaluation, dated 05/29/12, revealed the resident had the potential for habit, prompted, or scheduled toileting.</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 06/04/12, revealed the facility identified Resident #2 as cognitively intact with independent thinking abilities and needing the extensive assistance of two staff members for bed mobility, transfer, hygiene and toileting. The resident was frequently incontinent of bowel and always incontinent of bladder.</p> <p>A review of the resident's care plan, "At risk for recurrent Urinary Tract Infections (UTIs), related to a history of UTIs, having a non-ambulatory status and being incontinent of bowel and bladder revealed the goal was to remain free of UTIs. Interventions included encouraging fluid intake, monitoring for signs and symptoms of infection and measuring and recording output. There was no evidence of interventions for bowel maintenance, toileting schedules, nor evidence of bowel or bladder interventions on the care plan.</p> <p>However, observation of a skin assessment conducted on Resident #2, on 08/01/12 at 11:15</p>	F 280	<p>Continued from page 39</p> <p>4. The social worker will report to the DON each month how many residents attended their scheduled care conferences and how many residents requested additional conferences to discuss revisions to their plan of care. The Licensed Nurses are all assigned a group of residents to complete care plan reviews twice a month and add Individualize interventions. The Licensed nurses will review the plan of care twice a month for interventions that are individualized to the resident's care. A quarterly audit will be conducted, by the MDS coordinator, to review the plan of care for individualize interventions documented by the Licensed Nurses. Any identified trends or concerns will be reported to the MDS Nurse, Charge Nurse, ADON or DON quarterly beginning 8/22/12. A 24 hour review of all new orders will be conducted each day by the MDS Nurse, Charge Nurse, ADON or DON to determine if any care plan revisions are necessary related to the new orders. The DON will be responsible for ensuring care plans meet the needs of the residents and will be monitored during Care Plan conferences.</p> <p>5. All corrective actions completed 8/23/12.</p>		

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSDALE, KY 42164		
(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 280	<p>Continued From page 40</p> <p>AM, and a resident interview, on 08/03/12 at 1:50 PM, revealed the resident had a healing Stage III Pressure Sore to the coccyx and was able to verbalize needs effectively. There was no evidence of the resident having a colostomy, as mentioned in the care plan for discharge and self-care deficit.</p> <p>An interview with LPN #8, on 08/03/12 at 2:50 PM, revealed the nurse who transcribed a physician's order was responsible to revise and make new additions to the care plan.</p> <p>An interview with Registered Nurse (RN) #2, on 08/03/12 at 3:50 PM, and a review of the "Seven (7) Day Bowel or Bladder Observation," dated 05/29/12, revealed the resident was assisted to the toilet with results from 05/30/12 until 06/05/12. The observation period did not address the number of times the resident was incontinent of bowel and bladder and there was no plan of action. Additionally, the care plan for self-care deficit mentioned the resident had a colostomy. The RN stated she was not aware the resident ever had a colostomy.</p> <p>An interview with RN #6, on 08/03/12 at 4:35 PM, revealed the nurses on the floor completed a bi-weekly summary, utilizing the information in the care plan and "should have caught" the resident not having a colostomy, as well as interventions for bowel and bladder maintenance. The RN stated she tried to utilize the "Seven (7) Day Voiding Pattern" when completing quarterly and full MDS assessments, but the pattern for this resident was incomplete and lead to a lot of interviews with staff members and "chasing down papers."</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 466 BURNLEY RD. SCOTTSVILLE, KY 42164	
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F 280	Continued From page 41  An interview with the Director of Nursing (DON), on 08/03/12 at 6:20 PM, revealed she expected the licensed staff members to review and revise the care plans and stated "they have been trained."  2. A record review revealed the facility admitted Resident #15 on 08/07/10 with diagnoses to include a History of Multiple Fractures and Multiple Surgeries and Osteoporosis. An observation, on 08/03/12 at 11:15 AM, revealed the resident had a urinary catheter to bedside drainage.  A review of the significant change MDS assessment, dated 05/01/12, revealed the resident was moderately cognitively impaired and required the extensive assistance of two staff members for assistance with transfer, bed mobility and hygiene needs, always continent of bowel and frequently incontinent of bladder. A review of the High Risk for UTI care plan, dated 05/15/12, revealed an intervention for a urinary catheter to bed side drainage, dated 07/23/12. There was no evidence of interventions for the catheter.  An interview with RN #2, on 08/03/12 at 3:05 PM, revealed a specific care plan should have been implemented for the urinary catheter. Any nurse who receives an order for a catheter, can initiate a care plan and the RN would have expected the care plan to include monitoring for signs and symptoms of Infection, changes in the urine output, or the color and consistency of the urine, monitoring for an increase in pain levels and if there was a physician order, there should be an	F 280		

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 458 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 280	Continued From page 42 intervention for irrigation of the catheter, if needed.  3. A record review revealed the facility admitted Resident #3 on 07/25/12 with diagnoses to include Progressive Spinal Deformity with Kyphoscoliosis, Cerebral Vascular Accident and Depression. Review revealed an admission MDS had not been completed yet.  A review of the physician's orders, dated 07/27/12, revealed "Foley catheter, remove 08/01/12."  A review of the resident's initial care plan, "Bowel/Bladder Incontinence/Catheter Care. The goal was the resident will establish an individual bowel/bladder routine. Interventions that were checked included toileting how often, and keep call light in easy reach. Catheter care per policy was not checked.  An interview with the Assistant Director of Nursing (ADON), on 08/03/12 at 4:35 PM, revealed Resident #3 had a physician's order for a foley catheter on 07/27/12, to be removed on 08/01/12. She stated when the nurse received the order she should have updated the care plan for the foley catheter.  An interview with the DON, on 08/03/12 at 6:05 PM, revealed the nurse who transcribes a physician's order was responsible to make new additions to the care plan. She stated, "the nurse did not check the box for catheter care."	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	<i>F 282 It is the policy and routine practice of Cal Turner Rehab and Specialty Care to promote the care, and maintain or enhance the resident's dignity and respect. Services are provided by qualified persons in accordance with the resident's written plan of care.</i>	08/23/12	

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 282	<p>Continued From page 43</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced each residents' dignity and respect, for one resident (#12), in the selected sample of twenty-two (22) residents. During a transfer from the wheel chair to a standing position, Resident #12 was assisted by a staff member to stand while the staff member pulled on the back of the resident's slacks.</p> <p>Findings include:</p> <p>A review of the facility's "Transfer/Training Outline" policy/procedure, dated May 2011, revealed all residents, who required assistance with transferring, were to be transferred by the utilization of a gait belt.</p> <p>A record review revealed the facility admitted Resident #12 on 05/26/10 with diagnoses to include Advanced Senile Dementia, Hypertension, Anxiety and Chronic Obstructive Pulmonary Disease. A review of the annual Minimum Data Set (MDS), dated 06/05/12, revealed the facility assessed the resident as moderately cognitively impaired. The resident</p>	F 282	<p>Continued from page 43</p> <ol style="list-style-type: none"> <li>1. On 08/02/12, Resident #12 had been identified by the DON to be impacted. On 07/31/12 the DON identified that Nursing Assistant # 1 did have a gait belt available for use on 07/31/12. It was located in the drawer of resident # 12. Nursing assistant # 1 received performance counseling from Director of Nursing on 07/31/12. The performance counseling regarding failure to follow facility policy on transfer was documented and presented to Nursing Assistant #1 on 08/09/12 by the DON and Human Resources.</li> <li>2. All residents requiring assist of 1 or more and use of gait belt were identified on 08/20/12 by the MDS nurse to ensure that it was outlined on the plan of care. All resident plans of care were completed on 08/20/12 by the MDS nurse and ADON.</li> <li>3. Starting 08/17/12, the DON provided in-service training for nursing staff that addressed the policy and procedural guidelines for proper transfer techniques using of a gait belt. All nursing staff training was completed by the clinical educator and DON on 8/22/12.</li> </ol>		

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F 282	<p>Continued From page 44</p> <p>required limited assistance of one staff member with bed mobility and transfer. A review of the Nursing Assistant Care Plan, dated August 2012, revealed the resident was to be transferred with the assistance of one staff member and the use of a gait belt.</p> <p>An observation, on 07/31/12 at 4:15 PM, revealed Certified Nurse Aide (CNA) #1 assisted Resident #12, who was sitting in a wheel chair, to the bathroom. The CNA did not use a gait belt to assist the resident and pulled the resident by the back of his/her slacks to a standing position while the resident grabbed the bathroom grab bar.</p> <p>An interview with Resident #12, on 07/31/12 at 4:20 PM, revealed he/she was unaware he/she had an incontinent episode.</p> <p>An interview with CNA #1, on 07/31/12 at 5:20 PM, revealed she was aware of the policy for transferring residents with a gait belt, but was "nervous," and stated she "knew better" than to transfer the resident in this manner.</p> <p>An interview with Resident #12's family member, on 08/02/12 at 3:30 PM, revealed the family member complained about observing the resident being "pulled up" out of the wheel chair, by the back of the resident's slacks, but had not yet voiced a complaint to anyone.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 08/02/12 at 4:25 PM, revealed all the residents have gait belts available, in every resident's room and the staff members were not trained to pull residents up by the back of their slacks.</p>	F 282	<p>Continued from page 44</p> <p>4. Starting 8/22/12, ongoing competency assessment and compliance of staff for gait belt use will be monitored during rounding by the MDS Nurse, Charge Nurse, ADON or DON weekly for 6 months. Rounding results with a list of any staff observed not using proper transfer technique will be reported weekly to the DON. The report submitted to the DON will be maintained for tracking and performance review feedback to staff. Any staff members observed using incorrect technique will receive immediate re-education and counseling on transfer policy and procedural guidelines from the clinical educator, MDS Nurse, Charge Nurse, ADON or DON. Beginning 8/22/12, the Clinical Educator will provide transfer training using a gait belt to all nursing staff during unit specific orientation. The DON will be responsible for ensuring staff's compliance with this practice.</p> <p>5. Corrective actions were completed by 08/23/12</p>	

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F 282	Continued From page 45  An interview with the Director of Nursing (DON), on 06/15/12 at 12:05 PM, revealed she expected the staff to ensure the resident was transferred with a gait belt. She stated the staff members were trained to do this and it was required for transferring residents who required assistance at the facility.	F 282	<b>F 315</b> <i>It is the policy and routine practice of Cal Turner Rehab and Specialty Care to provide appropriate treatment and services to prevent urinary tract infections as outlined by the Centers for Disease Control.</i>	08/22/12	
F 315 SS=G	<b>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</b>  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 record review, staff and family interviews, and review of the facility's policy/procedure, it was determined the facility failed to ensure one resident (#11), in the selected sample of twenty-two (22) residents, was provided appropriate care and treatment related to an indwelling catheter. The facility failed to follow their Indwelling Urinary Catheter's policy and procedure. The facility failed to ensure timely care and services were provided to Resident #11 related to his/her catheter. The facility failed to ensure the care plan was followed as it relates to the resident's catheter and failed to	F 315	1. Resident # 11 was identified to be affected and had been assessed by RN #3 on 06/02/12 for any adverse reactions to a Foley Catheter. Resident # 11 met with his Urologist on 7/26/12 and cystoscopy was declined by the family because even if they found something they desired no interventions and comfort measures only. This visit included resident, spouse, and two daughters. Resident #11 had a standing order initiated on 1/11/11 by his primary physician to change the Foley Catheter every 30 days. On 08/02/12, an order was obtained from the resident's Urologist to irrigate his Foley Catheter as needed until clear. R.N. # 3 was counseled on 07/06/12 and again on 08/21/12 by human resources and the DON regarding the timeliness of catheter care delivered, reporting changes of conditions to the physician, and improving communication with families related to the progress of the care delivered. 2. All residents with Foley Catheters were identified by the MDS Coordinator and ADON on 8/3/12 to determine if irrigation occurred without a Physicians order or if any resident was experiencing discomfort related to their Foley catheter on 8/3/12. None were identified.		

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F 315	<p>Continued From page 46</p> <p>get a physician's order to irrigate Resident #11's bladder. On 06/02/12, at approximately 5:15 PM, family members reported to facility staff that Resident #11 was verbalizing, "I'm trying to pee," had a flushed face, and appeared to be in discomfort. While facility staff looked to see if the catheter was kinked, no further action was taken to assess or identify a problem with the catheter. Resident #11 continued to be in discomfort through the meal service. The family continued to request assistance for Resident #11. At approximately 6:45 PM, Licensed Practical Nurse (LPN) #2 irrigated Resident #11's bladder and emptied the catheter bag twice which resulted in Resident #11's relief from discomfort. Family members reported to Registered Nurse (RN) #3, on 06/02/12, that Resident #11 was complaining of pressure related to the indwelling catheter and his/her face was flushed. RN #3 adjusted the catheter tubing. For approximately one (1) hour the resident continued to be uncomfortable, and the family requested RN #3 to relieve the resident's discomfort. RN #3 delegated to staff to lay Resident #11 down. LPN #2 flushed the resident's catheter and reported the resident felt better. The family reported the incident to the Assistant Director of Nursing (ADON), on 06/05/12.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Indwelling Urinary Catheters," revised 12/11, revealed a physician's order is required for bladder irrigation.</p> <p>A review of the facility's policy/procedure, "Admission Assessment/Reassessment," last</p>	F 315	<p>Continued from page 46</p> <p>3. In-services were initiated 08/03/12 and completed by 08/08/12 with all nursing staff by the Clinical Educator regarding Policy and Procedural guidelines regarding catheter care and irrigation of Foley Catheters, to call a physician with any change in condition including voiced discomfort, and to assess with update to the plan of care for any resident with any signs and symptoms of urinary tract infection. L.P.N. # 2 will be counseled by the DON when she returns from medical leave on following policy and procedural guidelines to obtain physician orders for irrigating a Foley Catheter.</p> <p>4. Starting 08/17/12, daily 24 hour chart reviews will be conducted by a registered nurse (RN) each day. The RN will monitor all new orders and assure that the changes in resident's conditions are updated on the plan of care and communicated to physicians, the appropriate staff, and/or department(s). The monitoring will continue weekly for 6 weeks and if no concerns are identified the monitoring will continue monthly for another 6 months. The results of the monitoring will be reported to the DON by the respective RN. The DON and ADON will document any identified failures. All failures will be reported to the Administrator and Performance Improvement Committee quarterly.</p> <p>5. Corrective action was completed by 08/22/12</p>	

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F 315	<p>Continued From page 47</p> <p>revision date 12/11, revealed residents will be reassessed for pain if they exhibit signs of discomfort, restlessness, or receive PRN medications for pain, etc. The nurse will assess for severity using a pain scale, location, duration, intensity, etc. The resident will be assessed for the response to whatever measures are implemented. This will be documented on the Medication Administration Record (MAR) for as needed (PRN) medications or in the nurse's notes.</p> <p>A record review revealed the facility admitted Resident #11 on 05/29/10 with diagnoses to include Renal Failure, Alzheimer's Disease and Cerebral Vascular Accident.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 06/05/12, revealed the facility identified the resident with a Brief Interview for Mental Status (BIMS) score of five (5), which meant the resident was severely cognitively impaired, and requiring extensive assistance of two staff members for bed mobility, transfer, personal hygiene and toileting needs. The resident had an indwelling catheter and was frequently incontinent of bowel. A review of the physician's orders, dated 07/01/12, revealed "change foley catheter every thirty (30 days)." Review of the record revealed no additional orders related to the resident's catheter. A review of the resident's care plan, onset date 06/11/10, "At risk for Urinary Tract Infections (UTIs), related to indwelling catheter and urinary retention revealed the goal was to remain free of UTIs. Interventions included encouraging fluid intake, monitoring for signs and symptoms of infection, measuring and recording output,</p>	F 315			

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F 315	<p>Continued From page 48</p> <p>change catheter, tubing and bedside drainage bag monthly per physician's order, maintain closed drainage system, use aseptic technique when emptying bag and provide dignity cover over bedside drainage bag. However, there was no evidence of interventions for bladder irrigation.</p> <p>An interview with Family Member (FM) #1, on 08/02/12 at 7:35 PM, revealed she arrived at the facility on 06/02/12 at approximately 5:15 PM. She stated the resident was in the dining room and had a red face and his/her eyes were watering. She stated the resident kept repeating, "I am trying to pee." She requested a Certified Nurse Aide (CNA) in the dining room to ask the resident's nurse to come to the dining room. She stated she waited for approximately fifteen (15) minutes, and all the time the resident was straining and appearing to be in discomfort. She stated RN #3 came to the dining room and stated the catheter might be twisted. The family member stated the nurse looked up the resident's pant leg to about his/her knee, and the nurse did not appear to untwist the catheter. She stated that the nurse said his/her bag was full and just put it back in the dignity bag. The family member stated she then texted FM #2, and made her aware of Resident #11's condition. FM #2 stated she was on the way to the facility. FM #1 stated she pushed Resident #11 from the dining room back to the lobby at the nurse's station around 6:00 PM, approximately forty-five (45) minutes later. She stated the resident had tears rolling down his/her face and was still making grunting sounds. She stated she approached the nurse's desk and informed RN #3 that Resident #11 was still hurting. She said the nurse just sat there, but stated she would check the resident when they</p>	F 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/03/2012
NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 458 BURNLEY RD. SCOTTSVILLE, KY 42164		
(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 315	<p>Continued From page 49</p> <p>put him/her to bed. The family member stated the nurse did not tell CNAs to put the resident to bed. FM #1 stated FM #2 arrived at the facility and advised RN #3 that they were going to take Resident #11 to the Emergency Room (ER). FM #1 stated there was another nurse at the nurse's station, and she motioned for us to take the resident to his/her room. The nurse and another staff member took the resident to the bathroom and emptied the catheter bag and irrigated the catheter. FM #1 stated she heard the resident say, "Oh," like he/she was relieved. FM #1 stated after the nurse irrigated the catheter, the resident filled the bag up again, and then the resident was fine.</p> <p>An interview with FM #2, on 08/02/12 at 6:15 PM, revealed after reviewing her text messages, she had received a text message from FM #1, on 06/02/12 at 5:47 PM and 6:16 PM, stating Resident #1 was "having a hard time peeing and that his/her face was real red." FM #2 stated she texted FM #1 to have the nurse check his/her catheter. She stated FM #1 texted back that the nurse said she would check the resident when they put him/her to bed. FM #2 stated she arrived at the facility at approximately 6:45 PM. She stated she saw FM #1 sitting on the couch and Resident #11 had tears rolling down his/her face. She stated RN #3 was sitting at the nurse's station. FM #2 stated FM #1 told her she made the nurse aware of the resident's condition while in the dining room, and the nurse told her the catheter was not in a kink, the bag was full, and she would check it later. FM #2 stated FM #1 told her after returning to the nurse's station, she had reported to the nurse another two (2) to three (3) times that Resident #11 was "trying to pee." FM</p>	F 315			

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 468 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 315	<p>Continued From page 50</p> <p>#2 stated RN #3 advised her the catheter had been changed recently. FM#2 stated she told the nurse she did not care. "There is a problem now." FM #2 stated the nurse did not say anything and did not move from her seat. FM #2 stated a CNA approached her and asked if she could help. FM #2 stated she told the CNA, "I have already told the nurse. She is aware of the problem. We are going to the ER." FM #2 stated LPN #2 stated "Just take the resident to his/her room." She stated the LPN got the supplies and stated "I do not know why RN #3 did not flush the catheter." LPN #2 stated she had the resident last week, and he/she had the same problem, and all the catheter needed was to be flushed. FM #2 stated LPN #2 took Resident #11 to the bathroom. She stated when the resident came out of the bathroom, he/she was totally different. FM #2 stated she asked the resident if he/she felt better, and the resident stated "Oh, yes." FM #2 stated the resident was not red anymore.</p> <p>An interview with RN #3, on 08/02/12 at 4:50 PM, revealed she was the charge nurse for Resident #11 on 06/02/12. RN #3 validated the events on 06/02/12 specifying in the past she had been able to unkink the catheter tubing to get it to flow. She stated the tubing was kinked. The catheter started to flow, and the family member continued to feed the resident. RN #3 stated the resident didn't appear to be in any distress or pain. However, she stated it appeared there was some relief, because the resident was not saying he/she needed to "pee." She stated twenty (20) to thirty (30) minutes later, the family member brought the resident back to the lobby area at the nurse's station. RN #3 stated another family member arrived at the facility. She stated this</p>	F 315			

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F 315	<p>Continued From page 51</p> <p>family member asked her when the catheter had been changed, and when had the resident had a urinalysis, so she reviewed the chart. She further stated because the resident was still having discomfort she thought she would have to change the catheter related to sediment in the resident's urine. She stated she told FM #2 she would have the CNAs lay the resident down. RN #3 stated she had been unsuccessful in the past with irrigating the catheter, and was just going to change the catheter. She stated she went to get the CNAs out of another resident's room and asked them to lay the resident down. She further stated she realized the family was getting upset with her, and went a second time to get the CNAs. She stated she saw LPN #2 walking to the resident's room with the family members. She stated LPN #2 had the resident sit on the toilet and she irrigated his/her catheter.</p> <p>An interview with LPN #2, on 08/03/12 at 8:55 AM, revealed a family member of Resident #11 was visiting the resident. Around 6:00 PM, the family member asked her who the resident's nurse was because she thought the resident was uncomfortable and needed to go to the bathroom. LPN #2 informed RN #3 the family wanted to speak to her. She recalled the family member saying something about the resident still being uncomfortable. LPN #2 stated the resident's face was flushed, and he/she was restless in the wheel chair. She stated RN #3 said, she had checked the resident's catheter to see if it was kinked. She stated RN #3 stated she would lay the resident down after dinner and check the catheter to see if there was a problem. LPN #2 stated Resident #11 sat through dinner looking uncomfortable. At approximately 7:00 PM, the</p>	F 315			

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F 315	<p>Continued From page 52</p> <p>family member and Resident #11 were in the hallway. She stated the resident's face was flushed. She stated she asked two (2) CNAs to take Resident #11 to the bathroom. She stated she flushed the catheter. It started flowing and the resident got relief right away. She stated she did not think a resident should be left in that condition for over an hour. LPN #2 reviewed the physician's orders. She stated there was not a previous physician's order for irrigating the catheter. She also reviewed the care plan related to the urinary catheter and stated there should have been an intervention for irrigating the catheter.</p> <p>A review of the "Intake and Output Record," for 06/12, revealed there was no urine output recorded for 06/02/12 evening shift, after Resident #11's catheter was irrigated.</p> <p>Review of the nurse's notes, dated 06/02/12 at 5:15 PM to 7:00 PM, revealed there was no documented evidence the facility had been notified by the family of the resident's discomfort related to the catheter and no evidence the staff assessed the resident's catheter, notified the physician or received an order to irrigate the bladder.</p> <p>An interview with the Director of Nursing (DON), on 08/02/12 at 1:55 PM, revealed she was not sure if an order was required to irrigate the resident's catheter. She stated she would check the facility's policy. The DON further stated she did not know if RN #3 notified the physician related to the change in Resident #11's condition or the need to irrigate the catheter, because there was no documentation in the nurse's notes. The</p>	F 315		
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F 315	Continued From page 53 DON stated she, the ADON and Human Resources (HR) staff interviewed RN #3 after being made aware of the incident. However, she identified no concerns with the timeliness of catheter care. The DON stated they counseled RN #3 regarding the family's concern with timeliness of catheter care, and the discomfort and pain. The investigation completed by the facility did not identify that there was no documentation of the incident, no documented assessment of the resident and his/her catheter and no notification of the physician to get an order to irrigate the bladder.	F 315		
F 323 SS=E	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 observation, interview, and facility's policy and procedure review, it was determined the facility failed to ensure the residents' environment remained free of accident hazards as is possible for seven (7) wandering residents on B Hall and five (5) wandering residents on C Hall. The facility failed to ensure hazardous chemicals were not left out where wandering residents would have access to them.	F 323	<i>It is the policy and ongoing facility practice to ensure that residents at Col Turner Rehab and Specialty Care and their environments remain free of accidents and hazards, as well as receive adequate supervision to prevent accidents.</i>  1. On 07/31/12, the Administrator, Director of Nursing, and Facilities Manager identified 7 residents on B Hall and 5 residents on C Hall that may be impacted. On 08/03/12, all Hazardous Chemicals were secured by the DON where wandering residents do not have access to them.  2. On 07/31/12, the Administrator, Director of Nursing, and Facilities Manager did not identify any other residents as being impacted.	08/23/12

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F 323	<p>Continued From page 54</p> <p>A review of the Census and Condition, dated 07/31/12, revealed there were 107 residents in the building.</p> <p>Findings include:</p> <p>A review of the facility's Managing Hazardous Materials policy and procedure, last revised 01/2010, revealed the policy and procedure did not specifically address the storage of house cleaning and resident cleaning products when not in use.</p> <p>Interview with the Director of Nursing (DON), on 08/02/12 at 2:00 PM, revealed there were seven wandering residents on B hall and five wandering residents on C Hall.</p> <p>1. Observations, on 08/01/12 (Wednesday) at 10:20 AM, revealed:</p> <p>A. A spray bottle of "Odor Eliminator" was observed on top of the glove box that was mounted on the wall above the sink in the "C" Hall Residents' Day/ Activity area. The room was unlocked. A review of the product label revealed there was a warning to keep the product away from infants and children, avoid breathing the spray mist, and avoid contact with skin.</p> <p>B. Two (2) spray bottles of shower cleaner, were on the sink countertop on top of the wheelchair cleaning machine and on top of vanity in the shower room on C Hall. The shower room was unlocked. A review of the product label warning revealed to wear barrier protection such as gloves, gowns, masks, and eye coverings. The label also carried first aid instructions and</p>	F 323	<p>Continued from page 54</p> <p>3. Starting 8/17/12, all staff were in-serviced by the Clinical Educator or Education and Development staff on the revised Managing Hazardous Materials Policy. All remaining staff will be in-serviced by the Clinical Educator or Education and Development staff prior to starting their next scheduled shift. The Hazardous Materials policy was revised on 8/21/12 to ensure and protect residents from hazardous materials. When not in use, Hazardous Materials will be placed behind locked doors by staff at Cal Turner Rehab and Specialty Care. As of 08/22/12, the DON in-serviced all staff regarding the following information:</p> <p>a. Odor Eliminator-will be kept behind locked doors when not in use.</p> <p>b. Shower Cleaner-will be kept behind locked doors except when in use, and then returned upon completion of use behind locked doors</p> <p>c. Whirlpool Bath Cleaner- will be kept behind locked doors except when in use, and then returned upon completion of use behind locked doors</p> <p>d. Germicidal Wipes- Canisters of germicidal wipes are no longer in use at Cal Turner Rehab and Specialty Care, effective 8/4/12. The wipes were removed by DON and Materials Handler. Our current policy states that we will provide each resident a single use Castile Soap Towelette on their tray at each meal time.</p> <p>e. Foaming Hand Rub-will be kept only in their cradles when in use and not in use.</p>		

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F 323	<p>Continued From page 55</p> <p>chemical emergency instructions for a spill.</p> <p>C. A large bottle of whirlpool bath cleaner was in the lockable box connected to the whirlpool bath in the shower room on Hall C. The shower room and the door of the cleaner box were unlocked. A review of the product label precautionary statement revealed "danger may be fatal if inhaled. Do not breath mist. Do not get in eyes, or on skin and clothing. Wear goggles or face shield and rubber gloves when handling. Harmful or fatal if swallowed. Wash thoroughly with soap and water after handling. Remove contaminated clothing and wash before reuse. If inhaled, remove to fresh area and ventilate. Skin-immediately wash with plenty of water and get medical attention. If swallowed, drink one glass of water and get medical treatment. Do not induce vomiting. Note to physician- "probable mucosal damage gastric lavage may be contraindicated."</p> <p>D. Cannisters of germicidal wipes on each table (6) in the Activity Room on Hall B and the Dining Room on Hall C. A review of the label revealed the wipes were for external use only. Keep out of reach of children. Do not use in or near eyes, if swallowed, seek medical attention immediately or contact poison control center.</p> <p>E. There were four containers of foaming antimicrobial hand rub on the shelf in the shower room on Hall C. A review of the product label revealed it was for external use only, do not use in eyes, rinse promptly and thoroughly, if swallowed get medical help or call poison control center.</p>	F 323	<p>Continued from page 55</p> <p>4. Starting 08/08/12, weekly monitoring of activity areas, dining rooms, and shower room will be completed by the DON and/or ADON to make sure that hazardous materials are not in areas of concern and hazardous materials are kept behind locked doors when not in use to keep our wandering and non-wandering residents safe. Upon completion of each weekly audit, a report will be sent to Administrator and Facility Manager. After 6 consecutive weeks of audits, the audits will go to monthly if there are no trends of concern. The audit will be reported to Administrator and Facility Manager.</p> <p>5. Corrective Actions were completed by 8/23/12.</p>	
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F 323	<p>Continued From page 56</p> <p>Interview with Certified Nurse Aide (CNA) #11, on 08/03/12 at 11:00 AM, revealed Cavicide was the cleaner used to clean the shower and shower equipment after each resident's shower. The Cavicide was to be stored in the cabinet behind the shower room door when finished with resident showers. She stated the cleaner was obtained from the locked storage room down the hallway from the nurses' station. CNA #11 stated if the MSDS sheet or the product label said "keep out of reach of children" the product was locked up.</p> <p>Interview with CNA #12, on 08/03/12 at 1:50 PM, revealed the Cavicide shower cleaner was stored in the locked cabinet in the tub room, adjacent to the shower room. She stated the key to the cabinet was kept at the nurses' desk.</p> <p>Interview with CNA #15, on 08/03/12 at 5:00 PM, revealed the Cavicide shower cleaner was kept in a locked cabinet behind the nurses' station. She stated the cabinet stayed locked and the key would be found on the nurse's key ring with the medication room and medication cart keys. She stated she usually got a new bottle from the supply room that is also locked. CNA #15 stated she read product labels and stuff that needed to be kept out of reach would be kept in the resident's night stands.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 08/03/12 at 5:15 PM, revealed all cleaning supplies should be stored in the locked environmental closet.</p> <p>Interview with Registered Nurse (RN) #9, on 08/01/12 at 10:20 AM, revealed the germicide cleaning solution, shower cleaner, odor</p>	F 323		
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F 323	Continued From page 57 eliminator, and hand rub should be locked up when not in use by staff. She revealed the door to the box for the whirlpool cleaner should also be locked at all times. She was unable to provide an explanation as to why the items were left out in reach of wandering residents.  2. Additionally, an observation during initial tour, on 07/31/12 at 10:30 AM, revealed a bottle of Listerine and a bottle of Witch Hazel was on top of Resident #8's night stand.  A review of the product labels for each product revealed there was a warning to keep the product out of the reach of children, and it stated "if swallowed get medical help or contact a Poison Control Center right away."  An interview with LPN #5, on 08/01/12 at 9:50 AM, revealed if a resident had an order for Listerine and Witch Hazel at bedside, the resident may have the products.  Interview with the Facility's Manager, on 08/02/12 at 2:40 PM, revealed he conducted Hazardous Surveillance rounds, every Monday and Wednesday to identify hazards in the facility. He revealed the cleaning products identified in the shower rooms, activity room and dining room should be locked in cabinets and out of resident's reach when not in use. He stated the door to the cleaner for the whirlpool tub should have been locked.	F 323			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or	F 371	<i>F 371 It is the policy and practice of Cal Turner Rehab and Specialty Care to store prepare, and serve food under sanitary conditions for the protection and prevention of illness for the residents who consume food prepared by the facility.</i>	08/23/12	

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F 371	<p>Continued From page 58</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy and procedure review, it was determined the facility failed to store, prepare, and serve food under sanitary conditions. A review of the Census and Condition, dated 07/31/12, revealed 104 out of 110 resident ate food from the kitchen. The facility failed to ensure kitchen aides followed dietary policies and procedures: Food was observed not sealed or dated. Kitchen equipment and appliances were observed having debris and residue. Staff was observed not ensuring infection control practices were implemented during food preparation. Furthermore, the dishwasher venting system failed to adequately bent steam causing condensation to drip from the ceiling vent on to clean dishes.</p> <p>Findings include:</p> <p>Review of the facility's policy and procedure for Cleaning of Can Opener, Cleaning of Slicer, and Cleaning of Range, dated 08/12, revealed the equipment was to be cleaned after each use.</p> <p>Review of the facility's policy and procedure for Hot Holding of Food Before Service, dated 08/12, revealed foods should not be placed into the</p>	F 371	<p>Continued from page 58</p> <p>1. On 07/31/12, the Food Service Manager Identified that all residents may be impacted. The meat slicer, Robot Coupe, ice machine, can opener, drip pan below the stove burners, and vents inside the two door refrigerator were each cleaned immediately on 7/31/12 by cooks and kitchen aides. On 08/02/12, the Food Services Manager moved all dishes stored under the ceiling air vent. The Facilities Vice President wiped the ceiling air vent dry. The Facilities Manager instructed Food Service staff to stop washing dishes if the steam accumulated too much. The Administrator instructed staff to store dishes facing downward. The Food Services Manager changed how china and service ware was stored and instructed Food Service staff to store all china and service ware in racks to air dry. The Food Services Manager immediately identified the dates the food was received and opened and determined it was still appropriate to keep. The Cooks repackaged the opened foods and stored them in a zip-lock plastic bag that was labeled and dated.</p> <p>2. On 07/31/12, the Food Services Manager identified that all residents may be impacted.</p> <p>3. On 08/01/12, the policy was revised by the Food Service Manager to state food is no longer placed in the steam table more than 1 hour prior to meal service. All opened foods are stored in a zip-lock plastic bag, labeled and dated. All plated food is stored covered, dated and used within 24 hours.</p>	

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 371	<p>Continued From page 59</p> <p>steam table more than one hour prior to service.</p> <p>Review of the facility's policy and procedure for Unused Food Portions, dated 9/11, revealed any opened prepackaged food items were to be placed in zip lock bags, labeled and dated. Plated items were to be covered and dated, stored in the refrigerator and used within 24 hours.</p> <p>Review of the facility's policy and procedure for Use of Gloves, dated 9/11, revealed gloves were to be worn when touching any food item in the raw or ready-to-eat state and during serving meals. Hands must be washed prior to donning gloves and when changing to a new pair. Gloves were to be changed when soiled, between tasks, every 2 hours during a continual task, after handling raw meat, before touching ready-to-eat foods, after touching door handles, and any other activity that may contaminate the hands.</p> <p>Review of the facility's policy and procedure for Hand Hygiene, dated 9/11, revealed hand washing was expected before each shift, before handling food, before putting on gloves, after taking a break, after touching hair, skin, or clothing, after eating or drinking, after handling money, after toilet use, after handling soiled items or garbage, after coughing, sneezing, or blowing nose, and after removing gloves.</p> <p>1. Observations, on 07/31/12 at 9:55 AM, during the initial tour of the kitchen revealed:</p> <p>A. One opened plastic bag each of chicken breasts, chicken strips, chicken nuggets, country fried steak and french fries that were not sealed or dated and one open box of pie that was not</p>	F 371	<p>Continued from page 59</p> <p>On 08/15/12, Stewart Richey contractor came to evaluate remedies for steam accumulation. As of 08/22/12, all Food Service Staff including Kitchen Aides and Cooks were re-educated by the Food Service Manager on the proper cleaning and sanitizing procedures for the kitchen equipment. As of 08/22/12, all Food Service Staff including Kitchen Aides and Cooks were re-educated by the Food Service Manager on the preparation of food to conserve nutritive value, flavor, appearance and texture. As of 08/22/12, all Food Service Staff including Kitchen Aides and Cooks were re-educated by the Food Service Manager on the storage of opened and plated food items. As of 08/22/12, all Food Service Staff including Kitchen Aides and Cooks were re-educated by the Food Service Manager on the policy for hand hygiene and the proper use of gloves. In addition, as of 08/22/12, all Food Service Staff including Kitchen Aides and Cooks were re-educated by the Food Service Manager on the infection control policy and procedural guidelines which address leaning over the food service ware, equipment, and utensils. All china and service ware is stored in racks to air dry. As of 08/22/12, all Food Service Staff including Kitchen Aides and Cooks were re-educated by the Food Service Manager on the proper storage of china and service ware and the arrangement of service ware on the tray line.</p>		

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F 371	<p>Continued From page 60 dated in the walk-in freezer.</p> <p>B. Six (6) trays of small plates of cream pie and bowls of strawberries prepped for serving on an open shelf cart in the walk-in refrigerator. They were not covered and were open to the air.</p> <p>C. The meat slicer was stored and covered with a plastic bag. Removal of the covering revealed crumbs were located on the blade and below the blade.</p> <p>D. The Robot Coupe, used to puree foods had crumbs under the removable food container.</p> <p>E. The ice maker had black flakes of residue on the white gasket above the ice. The handle of the ice scoop was touching the ice.</p> <p>F. The heavy duty can opener had a thick layer of moist, black residue on the sharp edge and below the sharp edge.</p> <p>G. The drip pan below the stove burners was coated with a brown film.</p> <p>H. The two-door refrigerators inside air vents had a build up of dust and debris.</p> <p>Interview with Kitchen Aide #11, on 08/03/12 at 4:30 PM, revealed food was to be labeled with the date opened and the seventh (7th) day date as the "use by" date when stored in the refrigerator or freezer. She stated food was to be covered when stored. If stored for a long time the food was to be covered totally. If stored for a couple of hours a lid, saran wrap, or parchment paper was used. Kitchen Aid #11 stated when</p>	F 371	<p>Continued from page 60</p> <p>As of 08/22/12, all Food Service Staff including Kitchen Aides and Cooks were re-educated by the Food Service Manager on when to place the food into the steam table, storage of open foods, and plated foods. On 08/22/12, the Facilities Manager moved the ceiling air vent to prevent condensation from dripping on clean china and service ware. On 08/22/12, the Food Services Manager instructed staff to stop washing dishes if condensation builds up on ceiling surfaces and to wipe dry ceiling surfaces.</p> <p>4. The following monitoring started as of 08/21/12:</p> <p>a. The Food Service Manager and Team Leaders began monitoring the cleaning schedule daily and will continue monitoring for 8 weeks.</p> <p>b. The Food Service Manager, Team Leaders, Cooks and Kitchen Aide began monitoring twice per shift the appropriate storage of the ice scoop for the ice machine in accordance to facility policy. Monitoring will continue for 8 weeks.</p> <p>c. The Food Service Manager, Team Leaders, Cooks and Kitchen Aide began monitoring daily the cleaning and sanitizing schedule of equipment and will continue to be monitored 8 weeks.</p> <p>d. The Cooks will monitor and record at each meal the times they place the food in the steam table on the daily log and check list for the tray line.</p>		

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 371	<p>Continued From page 61</p> <p>cleaning equipment anything that could be placed in the sink was cleaned in the sink using the three (3) step washing process. She specified the meat slicer, the can opener, and the Robot Coupe as being taken apart and cleaned in the sink with the motorized part being wiped with a rag. She stated she was not trained on the cleaning of the equipment.</p> <p>Interview with Kitchen Aide #10, on 08/03/12 at 4:45 PM, revealed all food was to be covered when in the refrigerator or freezer and when opened, it was to be resealed and dated for three (3) day or seven (7) day expiration according to the food. She stated the meat slicer was to be cleaned after each use and covered after the cleaning; tables cleaned every day; Robot Coupe cleaned after each use; the can opener and drip pan under the stove burners were cleaned according to a schedule provided by the Dietary Manager. After the cleaning was completed, the kitchen staff was to initial the schedule.</p> <p>Interview with the Dietary Manager, on 08/03/12 at 9:00 AM, revealed he provided in-services for kitchen staff monthly related to the cleaning of equipment. He stated he had hand written sign-in sheets for the monthly in-services but was unable to provide copies of those signature sheets when requested.</p> <p>Interview with the Dietician, on 08/02/12 at 2:30 PM, revealed any opened food stored in the freezers and refrigerators should be sealed and dated. Food that is prepared prior to meal placed in individual bowls and on plates to serve to resident and stored in refrigerator prior to service should be covered. She stated the meat slicer</p>	F 371	<p>Continued from page 61</p> <p>e. The Food Service Manager will monitor all storage of opened food items and plated food twice a week during the inventory of food supplies and the Team Leaders and Cooks will monitor daily of the storage of opened food items and plated food.</p> <p>f. The Food Service Manager, Dietitian and Team Leaders will monitor the tray line staff weekly for glove use, that the equipment is placed correctly for service, and monitor daily the proper storage of china and service ware.</p> <p>g. The Food Services Manager and Team Leaders will monitor the dish room ceilings daily to ensure condensation does not build up and drip.</p> <p>h. The Food Services Manager is responsible to ensure staff's compliance with these processes.</p> <p>5. Corrective Actions were completed by 8/23/12</p>		

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F 371	<p>Continued From page 62</p> <p>and can opener should be cleaned after every meal if used and the ice scoop should be stored out of the ice.</p> <p>2. Observation of the dietary tray preparation line, during the lunch meal on 07/31/12 at 11:40 AM, revealed:</p> <p>A. Kitchen Aide #11 was wearing gloves and placing bread on small plates. She left the tray line to get additional plates and returned to the tray line. She did not change gloves or wash her hands after leaving the tray line or before returning to the tray line. She also leaned over the clean plates with her scrub top resting fully on the plates each time she passed the bread plate across the tray line to the residents' trays.</p> <p>Interview with Kitchen Aide #11, on 08/03/12 at 4:30 PM, revealed she was not provided training hand washing and glove use but had knowledge from a previous job. She stated the training she received was when she was hired and was an online program completed on her own. She stated she had received verbal instructions from co-workers and from the Dietary Manager related to general job duties in the kitchen but no job specific instructions.</p> <p>B. Kitchen Aide #10 did not change gloves or wash hands while she obtained Styrofoam bowls from below the steam table, took a knife from the utensil rack and returned to the sink to prep lettuce and slice tomato for residents' trays.</p> <p>Interview with Kitchen Aide #10, on 08/03/12 at 4:45 PM, revealed her knowledge of hand washing was to wash for 15 seconds and wash to</p>	F 371		

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F 371	<p>Continued From page 63</p> <p>her elbows. She stated sometimes she forgets to change gloves and wash her hands before gloving again but most of the time she changes after every task. She stated her training was done on the computer with the online programs completed on her own.</p> <p>Interview with the Dietary Manager, on 08/03/12 at 9:00 AM, revealed he provided in-services for kitchen staff monthly to cover topics such as hand washing, use of gloves and food borne illness. He stated he had hand written sign-in sheets for the monthly in-services but was unable to provide copies of those signature sheets when requested.</p> <p>Interview with the Dietician, on 08/02/12 at 2:30 PM, revealed staff should change gloves when changing task and wash hands in between removing old and applying new gloves.</p> <p>3. Observation of the dishwasher area, on 08/02/12 at 9:00 AM, revealed when the dishwasher was running steam rolled out of the left and right sides of the dishwasher. The exhaust fan, directly above the dishwasher, removed a minimal amount of steam from the room. The steam filled the room and allowed moisture to accumulate on the ceiling air vent which then dripped onto the clean dishes removed from the dishwasher. All flat surfaces were coated with moisture and inverted cups and bowls were placed on the moist surfaces to dry when removed from the dishwasher.</p> <p>Interview with the Facility's Manager, on 08/02/12 at 9:25 AM, revealed the exhaust fan didn't work like it should when the humidity was high outside.</p>	F 371		

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F 371	Continued From page 64	F 371		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p>	F 441	<p><i>F 441 It is the policy and routine practice of Cal Turner Rehab and Specialty Care to promote hand hygiene in accordance with CDC guidelines to prevent infection within our population.</i></p> <p>1. On 07/31/12, the DON identified residents #6 and #12 that was impacted. Upon notification on 08/03/12, the DON immediately investigated which staff members were involved. It was determined that C.N.A. # 17 was trained by the Clinical Educator on 02/15/11 regarding Standards of Nursing Care including policy and procedural guidelines of Hand Hygiene Techniques during the C.N.A.'s New Employee Orientation. Competency assessment and direct observation for correct hand hygiene performance of C.N.A. #17 was monitored by the A.D.O.N. on 08/02/12. C.N.A #17 received performance counseling on 08/09/12 from the D.O.N. and Human Resource. On 08/03/12, the soiled cushion was removed, laundered, and the wheelchair washed by environmental services staff.</p> <p>2. On 08/01/12, the DON and ADON rounded and inspected wheelchairs and compliance with Hand Hygiene Techniques. Starting (08/01/12), weekly rounding was conducted by the ADON to monitor infection prevention practices of staff. No additional failures were identified. No other residents were affected.</p>	08/23/12

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F 441	<p>Continued From page 65</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Infection Control policy and procedure, it was determined the facility failed to ensure appropriate use of gloves and handwashing during incontinent care for two residents (#6 and #12), in the selected sample of twenty-two (22) residents.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Handwashing/ Cleansing Techniques," dated October 1978, and "Infection Control Policies and Procedures," dated June 1996, revealed hands should be washed: "After patient contact and after gloves are removed; When hands are visibly soiled; When hands are contaminated with blood, body fluids, secretions or excretions, or have touched equipment or articles contaminated with them; And standard precautions, as outlined by the Centers for Disease Control Center (CDC) shall be practiced."</p> <p>1. An observation of incontinent care, on</p>	F 441	<p>Continued from page 65</p> <p>3. Starting 08/17/12, the Clinical Educator in-service staff on Policy and Procedural guidelines for hand hygiene, including return demonstration and handling of contaminated linen/equipment. The remaining in-service training for staff was provided by the DON and clinical educator. All in-service training of staff on Policy and Procedural guidelines for hand hygiene, including return demonstration and handling of contaminated linen/equipment was completed by 08/22/12.</p> <p>4. Starting 08/22/12 the ADON will conduct weekly secret surveillance monitoring with direct observation of hand hygiene on all shifts for 6 weeks. Starting 08/22/12, ongoing monitoring for the next 12 months will be conducted by the MDS Nurse, Charge Nurse, ADON or DON on each unit and reported to the Infection Prevention Manager monthly. If there are no failures the ADON will conduct monthly secret surveillance monitoring with direct observation of hand hygiene beginning 08/22/12. The results will be reported by the ADON to the infection Prevention Manager quarterly.</p> <p>5. Corrective actions were completed by 08/23/12</p>	

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F 441	<p>Continued From page 66</p> <p>07/31/12 at 4:15 PM, revealed Certified Nurse Aide (CNA) #17 donned gloves and assisted Resident #12 to stand from a seated position in the wheel chair. There was a large brown area to the back of the resident's slacks and a large area of a brownish substance to the front of the resident's wheel chair cushion. The resident's brief was removed and the stool had smeared to the resident's lower back area. The resident was able to hold on to the grab bar, near the toilet, while the CNA wiped stool from the resident's lower torso with a peri-wash solution and toilet tissue. The resident tired easily and was assisted to sit on the toilet seat that was visibly soiled with stool, which was not cleaned during the episode. With visible stool on her glove, the CNA donned clean gloves, without washing her hands and continued to try and clean the resident. The CNA then assisted the resident with repositioning his/her clothing and prior to removing the gloves, wheeled the resident out of the bathroom, and touched the wheel chair arms and put on the resident's house shoes. The foam cleaner the CNA used was held by the resident, who handed this, to the CNA. The CNA took off one of the gloves and placed the foam cleaner, on the resident's night stand and took the resident's soiled clothing, that was bagged, to the soiled linen room, having not washed her hands and still wearing one of the soiled gloves.</p> <p>An interview with CNA #17, on 07/31/12 at 5:20 PM, revealed she knew she should have removed her gloves and washed her hands and was "just nervous."</p> <p>An observation of Resident #12's wheel chair on 07/31/12 at 4:15 PM, on 08/01/12 at 9:20 AM, on</p>	F 441		

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F 441	Continued From page 67 08/02/12 at 11:00 AM, and on 08/03/12 at 3:23 PM, revealed the brownish substance to the padded cushion had not been cleaned.  An interview with RN #2, on 08/03/12 at 3:50 PM, revealed she was not aware of the resident's wheel chair cushion having been soiled. The RN questioned the staff and stated the brown substance was from where the resident had been dipping snuff. The RN stated the wheel chairs were cleaned weekly and was due to be cleaned "tonight."  2. An observation of incontinent care for Resident #6, on 08/01/12 at 10:47 AM, revealed CNA #17 donned gloves, wiped stool, bagged the linen and the soiled brief. She then placed a clean brief on the resident after a hands-on assist to turn and reposition the resident. The CNA touched the resident's hips and hands, assisted the resident to put on gripper socks and a left hand brace and then assisted the resident into the lift sling, touched the lift controls and a geri-chair. The CNA then brushed the resident's hair with a hair brush, prior to taking off the soiled gloves.  An interview with CNA #17, on 08/01/12 at 10:47 AM, revealed she should have changed the gloves "each time and washed hands in between."  An interview with the Director of Nursing (DON), on 08/03/12 at 6:20 PM, revealed the CNAs should have washed their hands and changed their gloves. The DON stated the staff members were trained on the proper procedures.	F 441		
F 490	483.75 EFFECTIVE	F 490	F 490 The facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	08/22/12

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F 490 SS=L	<p>Continued From page 68 ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and procedure/in-services, and review of the Administrator's job description revealed the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being. The Administrator failed to ensure the facility had detailed written plans and procedures that addressed the mechanisms used to unlock doors so that facility's staff could evacuate residents in the event of an emergency or disaster. The Administrator failed to ensure staff was trained and procedures were periodically reviewed with staff related to the use of these mechanisms to unlock the emergency exit doors in the event of an emergency or disaster. In addition, the Administrator failed to follow Life Safety Code procedures to ensure staff was able to readily unlock emergency exit doors at all times for means of egress.</p> <p>The failure of the Administrator to ensure staff was able to unlock the emergency exit doors to evacuate residents timely, in the event of an emergency or disaster is likely to cause serious injury, harm, impairment, or death to a resident.</p>	F 490	<p>Continued from page 68</p> <p>1. On 07/31/12, the Administrator, Director of Nursing, and Facilities Manager identified that all residents may be impacted. Corrective action was taken immediately. All exit doors were unlocked on 07/31/12 by the Engineering staff.</p> <p>2. On 07/31/12, all residents with Roam Alert bracelets were identified by Engineering staff. Residents wearing the Roam Alert bracelet for safety to prevent elopement were identified as activating the electronic/magnetic lock on exit doors. The bracelet function of each resident was tested by the Engineering staff on 07/31/12 and is tested ongoing on a weekly basis thereafter for 12 months for correct functioning. Any resident that requires a new bracelet for safety purposes will be reported to Engineering by the Charge Nurse. Nursing will test each new Roam Alert bracelet before placing on the resident to ensure it functions appropriately. On a weekly basis, Engineering will test the battery on each Roam Alert bracelet in use to ensure it functions appropriately.</p> <p>3. a. On 07/31/12, the Engineering staff changed the locking system configuration to be unlocked at all times. As of 07/31/12, all staff can readily exit and evacuate through the unlocked doors. The unlocking function using the pass code, ID badge, and Fire Alarm system testing for situations where Roam Alert bracelets locked doors was tested on 07/31/12 by the Engineering staff and were found to function correctly. The ID badge and pass code testing will continue to be checked weekly by the Engineering staff. The fire alarm testing will be continued three times per month thereafter by the Engineering staff.</p>	

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F 490	<p>Continued From page 69</p> <p>Immediate Jeopardy was identified on 07/31/12 and determined to exist on 07/31/12. An acceptable AoC was received on 08/03/12. The AoC was verified on 08/03/12 and it was determined the Immediate Jeopardy was removed on 08/02/12, as alleged in the AoC. The S/S was lowered to a "F", based on the facility's need to continue to evaluate the implementation of changes and quality assurance activities.</p> <p>Refer to F517 and F518.</p> <p>Findings include:</p> <p>A review of the Vice President/Administrator's job description, last revised 01/2011, revealed the Administrator should work collaboratively with department heads and clinical managers to identify and optimize opportunities for improvements at the long term care facility and conduct disaster preparation demonstrating knowledge and understanding of assigned roles and responsibilities.</p> <p>Observations of all four exit doors with Facility Manager revealed they were in lock down mode which prevented emergency egress through the door in the event of an emergency requiring evacuation.</p> <p>Observations on 07/31/12 at 4:30 PM, 4:43 PM, 4:50 PM and 4:53 PM, revealed one staff's (Facility Manager) badge failed and several staff did not have their badge on their person. Four staff was unsuccessful in immediately unlocking the exit doors upon request to demonstrate their ability to assist in egress and evacuation.</p> <p>Interviews with nine staff including the Clinical</p>	F 490	<p>Continued from page 69</p> <p>b. Roam Alert and Wandering Risk Precautions policies and procedural guidelines related to mechanisms for exiting/evacuating the building were revised on 07/31/12 by the DON to reflect the use of the pass code, ID Badge, and Fire Alarm system. These revisions were communicated to staff by the DON and Clinical Educator on 07/31/12 and 08/01/12 via email, computerized based learning module, and during return demonstrations by staff. Emergency Management policies and procedural guidelines related to the use a badge swipe, pass code, or fire alarm for evacuation were revised by our Facilities Vice President on 08/20/12. All Emergency Management policies and procedural guideline revisions were communicated to all staff by email on 08/20/12.</p> <p>c. The Clinical Educator developed an in-service program on 07/31/12 to educate staff on the new standardized pass code, badge swipe bypass, and fire alarm bypass methods when needed to unlock the Roam Alert lockdown if activated by a Roam Alert bracelet. The Director of Nursing, Assistant Director of Nursing and the Clinical Educator initiated in-service training 07/31/12. All remaining Long Term Care staff who had not returned to work since 07/31/12 completed their training by 08/21/12. The in-service training also included revisions to the Roam Alert and Wander Risk Precautions policies and procedural guidelines regarding the new standardized pass code.</p>	

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F 490	<p>Continued From page 70</p> <p>Educator who trains staff revealed the staff was not knowledgeable of the pass code.</p> <p>A review of the Emergency Operation Plan and Emergency Management Plan revealed they were last reviewed on 01/2012; however, there was no evidence the plans detailed the locking mechanism on the doors, that the doors were maintained in lock down, or the mechanisms used to unlock the doors. Furthermore, interview with the Administrator, on 08/01/12 at 2:45 PM, revealed he was not aware the facility's emergency plans and procedures did not address the use of a pass code to ensure staff were able to evacuate residents in the event of an emergency or disaster. Additionally, interview with the Clinical Educator, revealed he trained new employees on the emergency system but was unaware of the pass code. Interview with the Administrator revealed he was not aware the staff were not trained on the bypass code for the emergency exit doors. He was aware there were no competency checks completed with staff to ensure they were able to bypass the locked emergency exit doors. He revealed the staff would not be able to open the emergency exit doors timely if the staff did not have functioning name badges or if the alarm system was not functioning appropriately.</p> <p>The facility submitted an acceptable Allegation of Compliance on 08/02/12 which alleged the removal of Immediate Jeopardy on 08/01/12. The State Agency verified Immediate Jeopardy was removed on 08/02/12, through the following review:</p> <p>Interviews with the Vice President of Facilities</p>	F 490	<p>Continued from page 70</p> <p>Initial orientation competencies for new hires were revised by the Clinical Educator on 07/31/12 to include the use of the new standardized pass code for the Roam Alert system. All new staff will be in-serviced by the Clinical Educator prior to starting their first scheduled shift. The Clinical Educator will ensure all existing staff demonstrate ongoing competency annually when assigned their annual competencies. Any staff needing a new badge will receive it from Engineering once they have been put into the Roam Alert System and prior to the beginning of their next shift. In the event an employee fails to demonstrate competency in using the badge swipe, pass code, and fire alarm, the employee will be removed from long term care.</p> <p>4. a. Engineering staff initiated the following monitoring starting 07/31/12:</p> <ul style="list-style-type: none"> <li>i. Weekly testing of doors to ensure they remain unlocked and open appropriately.</li> <li>ii. Weekly testing for Roam Alert system to include:             <ul style="list-style-type: none"> <li>1. Roam Alert bracelet activation of locking mechanism</li> <li>2. ID badge and pass code bypass to unlock doors when activated by the Roam Alert Bracelet.</li> <li>iii. Fire alarm testing three times per month to ensure doors will unlock after being activated and locked by the Roam Alert Bracelet.</li> </ul> </li> </ul>	
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F 490	<p>Continued From page 71</p> <p>and the Administrator, on 08/02/12 at 4:25 PM and 4:33 PM, revealed they investigated and determined the exit doors could be placed in an unlocked status and if the Roam Alert Status was activated to lock the doors that staff could use their badge swipe, pass code, or fire alarm to bypass the locking mechanism on 07/31/12.</p> <p>Observations of the emergency exit doors and interview with the Facility Manager, on 08/02/12 at 5:12 PM, revealed: 1) the locking function of the exit doors was changed to being unlocked at all times on 07/31/12. 2) A standardized bypass code was programmed in the exit doors for all staff to use in cases where the Roam Alert system becomes active and there is a need to unlock the door. 3) The Engineering Staff initiated checking to ensure the standardized code would unlock the doors when the Roam Alert system was activated on 07/31/12. This function will continue daily through 08/05/12, then weekly thereafter. 4) the Engineering staff initiated testing of the fire alarm system to ensure the doors were unlocked in cases of fire alarms or power failures. This will continue daily through 08/05/12 and three times a month thereafter. A review of the Fire Alarm Function Monitoring, Pass code Function Monitoring and Badge Swipe Function Monitoring forms revealed the checks were completed daily from 08/01/12 to 08/03/12 (last day of survey).</p> <p>Interview with the Clinical Educator, on 08/02/12 at 5:27 PM, revealed he initiated training of all staff in the building, on 07/31/12, on how to use the badge swipe, new standardized pass code and fire alarm pull station to bypass the Roam Alert locking mechanism. This included the</p>	F 490	<p>Continued from page 71</p> <p>b. The Facilities Manager revised the Hazardous Surveillance tool to monitor staff's ongoing competency monthly using the new standardized pass code. Ongoing annual drills will be performed by Engineering staff to test the evacuation process to ensure staff know how to exit doors. All results of testing, Hazardous Surveillance, and annual evacuation drills will be reported quarterly to the Safety Sub-Committee (Administrator, Facilities Vice President, Corporate Security Officer, Facilities Manager, DON &amp; Clinical Educator). Policy and Procedural guidelines for Roam Alert, Wandering Risk Precautions will be reviewed annually by the DON. Emergency Management policies and procedural guidelines will be reviewed annually by the Safety Sub-Committee. The Facilities Manager will be responsible for ensuring staff's compliance with all processes.</p> <p>5. All corrective actions were completed by 08/22/12.</p>	

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F 490	Continued From page 72 revisions to the Roam Alert and Wander Risk precautions policies and procedural guidelines regarding the standardized pass code. All staff not present would be educated before working their next scheduled shift. He also revealed he updated the new employee orientation on 07/31/12, to include the new standardized pass code. He stated he developed a computer based learning module for ongoing staff competency training. This material was distributed to all staff on 07/31/12 and will be completed by all staff prior to their next scheduled shift. A review of the inservice documentation, dated 07/31/12 and 08/01/12, revealed all staff were trained on how to use the badge swipe, new standardized pass code and fire alarm pull station to bypass the Roam Alert locking mechanism. A review of the Roam Alert System policy and procedure, last revised 07/2012, revealed it was revised to include to exit the facility by an outside door, swipe you badge and push the door open at the handle, the doors can be deactivated by a badge swipe, entering the pass code, or pulling the fire alarm station to exit and push the door open at the handle, and if you obtain a new badge, notify engineering before working your scheduled shift. Observations and interviews with RN #2, LPN #2, LPN #3, Housekeeper #4 and #6, CNA #3, CNA #8 and a Unit Clerk, on 08/02/12 at 7:00 PM, 7:10 PM, 7:15 PM, and 7:20 PM, and on 08/03/12 at 9:42 AM, 9:47 AM, 9:50 AM and 9:55 AM, respectively, revealed they were able to open the emergency exit doors with their name badges and with the pass code. The staff revealed they received inservicing and computer module training related to exiting the emergency exit doors with their badges, pass code and fire alarm. The staff stated	F 490		

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F 490	<p>Continued From page 73</p> <p>Administration also had them demonstrate that they were able to open the doors with the pass code and name badge.</p> <p>Interview with the Director of Nursing, Assistant Director of Nursing, and Clinical Educator, on 08/02/12 at 12:30 PM, 5:27 PM and 6:27 PM, respectively, revealed all scheduled staff completed a return demonstration competency on how to bypass locked doors prior to working. All remaining employees will do a return demonstration prior to working the next scheduled shift. A review of 2012 Competency Program Attendance Records, dated 08/01/12, revealed all staff demonstrated the use of the name badge and pass code to bypass the roam alert locking mechanism. The Clinical Educator stated he revised the initial competency tool and the Facilities Manager revised the Hazardous Surveillance tool to assess staff's ongoing competency using the new standardized pass code. A review of the Initial Placement Competency Assessment and and Hazard Surveillance Tool revealed the tools included a competency to use employee badge and pass code to bypass the Roam Alert locking mechanism. The staff revealed if an employee failed to demonstrate competency in using the badge swipe, pass code, and fire alarm, the employee will be removed from long term care.</p> <p>Based on the above observations, interviews and documentation reviews, it was determined the Immediate Jeopardy was removed, effective 08/02/12, with the scope and severity lowered to a "F."</p>	F 490	<p>F 514 <i>It is the policy, and routine practice of Cal Turner Rehab and Specialty Care to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete ; accurately documented; readily accessible; and systematically organized.</i></p>	08/23/12
F 514 SS=G	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		

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F 514	<p>Continued From page 74</p> <p>LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation report, and review of the facility's policy/procedure, it was determined the facility failed to maintain a complete clinical record related to nurse's notes and intake and output for one resident (#11), in the selected sample of twenty-two (22) residents. The facility failed to follow their "Documentation" and "Intake and Output" policies and procedures. On 06/02/12, family requested care for Resident #11's catheter due to his/her discomfort, flushed appearance and watery eyes. The staff delayed in providing timely care and services for more than one hour. The facility failed to ensure accurate documentation related to care and services and the condition of Resident #11. The facility, at approximately 6:45 PM, irrigated the bladder and emptied the catheter bag twice; however there was no documentation in the medical record.</p>	F 514	<p>Continued from page 74</p> <p>1. On 08/02/12, Resident #11 had been identified by the DON to be impacted. The DDN met with RN# 3 on 8/21/12 and reviewed policy and procedural guidelines regarding documenting resident's condition.</p> <p>a. Performance Counseling was delivered to RN #3 on 8/21/12 by the DON regarding:</p> <ol style="list-style-type: none"> <li>i. failure to notify the physician of a change in a residents condition</li> <li>ii. failure to complete documentation in the clinical record</li> <li>iii. failure to obtain a physician order to irrigate the foley catheter</li> <li>iv. failure to document the resident assessment</li> <li>v. failure to document notification of the family related to the incident.</li> </ol> <p>b. Performance Counseling will be delivered by the DON to LPN #2 on the date she returns from medical leave regarding</p> <ol style="list-style-type: none"> <li>i. documentation in the medical record</li> <li>ii. failure to notify the physician of a change in a residents condition</li> <li>iii. failure to complete documentation in the clinical record</li> <li>iv. failure to obtain a physician order to irrigate the Foley catheter</li> <li>v. failure to document the resident assessment</li> <li>vi. failure to document notification of the family related to the incident</li> </ol>		

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F 514	<p>Continued From page 75</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, Documentation, effective date 06/06 and last revised 09/11, revealed "The licensed nurse is responsible for maintaining accurate nursing documentation in the medical record."</p> <p>A review of the facility's policy/procedure, Intake and Output, effective date 04/96 and last revised 07/12, revealed "If the resident has a catheter drainage bag or other drainage collection device in place, empty at the end of the shift and record the amount."</p> <p>A record review revealed the facility admitted Resident #11 on 05/29/10 with diagnoses to include Renal Failure, Alzheimer's Disease and Cerebral Vascular Accident.</p> <p>During initial tour of the facility, on 07/31/12 at 4:10 PM, a family member voiced concerns with the care Resident #11 received related to his/her catheter.</p> <p>A review of the facility's Investigation Report, dated 06/08/12, revealed Resident #11's family reported to the Assistant Director of Nursing (ADON), on 06/05/12, that they had reported to Registered Nurse (RN) #3 about Resident #11's complaint of pressure and his/her face being flushed. It was documented in the report that RN #3 responded to the resident and adjusted the catheter to ensure flow of urine to the bag. She reviewed the chart and the catheter had been recently changed. The report further revealed the family member approached RN #3 again, and RN</p>	F 514	<p>Continued from page 75</p> <p>2. All residents with Foley Catheters since 06/02/12 were identified by the MD5 Coordinator on 8/3/12 to determine if any other resident had a change in condition that warranted notification of the physician or missing documentation. None was noted through 8/22/12.</p> <p>3. Monitoring was conducted 8/22/12 by the MDS nurse for every resident's intake and output record for the month of August. All discrepancies identified were reported immediately to the DON and education or performance counseling's were delivered by the DON to all staff responsible for failure to maintain clinical records in accordance with established standards. Beginning on 08/03/12 and completed by 8/22/12, the Clinical Educator provided in-service training regarding the policy of Documentation and recording Intake and Output.</p> <p>4. Weekly monitoring by licensed staff of Intake and output records began 8/21/12. Any future deficiencies will be reported immediately by license staff to the ADON. The ADON will report documentation deficiencies quarterly to the Performance Improvement Coordinator and to the PI committee.</p> <p>5. Corrective actions were completed by 08/23/12</p>	
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F 514	<p>Continued From page 76</p> <p>#3 agreed to lay Resident #11 down and assess the resident. The report further revealed RN #3 delegated staff to lay Resident #11 down, and Licensed Practical Nurse (LPN) #2 flushed the resident's catheter.</p> <p>An interview with Family Member (FM) #1, on 08/02/12 at 7:35 PM, revealed, on the evening of 06/02/12, the nurse and another staff member took the resident to the bathroom and emptied the catheter bag and irrigated the catheter. FM #1 further stated, after the nurse irrigated the catheter, the resident filled the catheter bag up again, and then the resident was fine.</p> <p>A review of the "Output Record," for 06/12, revealed there was no urine output recorded for 06/02/12 on the evening and night shifts. Furthermore, a review of the nurse's notes revealed there was no documentation in Resident #11's chart between 05/29/12 and 06/06/12, thus detail of the family's concern voiced related to Resident #11's discomfort with the catheter, LPN #2's corrective action taken to assess and identify the need to irrigate the bladder and the relief obtained by the care provided, was not maintained in the record.</p> <p>An interview with the ADON, on 08/03/12 at 4:35 PM, revealed she was unable to determine if Resident #11's catheter had been irrigated, because she found no documentation in the nurse's notes. She further stated she did not review Resident #11's output record.</p> <p>An interview with the Director of Nursing (DON), on 08/02/12 at 1:55 PM, revealed she did not know if RN #3 notified the physician related to the</p>	F 514		

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F 514	Continued From page 77 change in Resident #11's condition or the need to irrigate his/her catheter, because there was no documentation in the nurse's notes.	F 514	<p><b>F 517</b> <i>The facility has detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.</i></p> <ol style="list-style-type: none"> <li>1. On 07/31/12, the Administrator, Director of Nursing, and Facilities Manager identified that all residents may be impacted. Corrective action was taken immediately. All exit doors were unlocked on 07/31/12 by the Engineering staff.</li> <li>2. On 07/31/12, all residents with Room Alert bracelets were identified by Engineering staff. Residents wearing the Room Alert bracelet for safety to prevent elopement were identified as activating the electronic/magnetic lock on exit doors. The bracelet function of each resident was tested by the Engineering staff on 07/31/12 and is tested ongoing on a weekly basis thereafter for 12 months for correct functioning. Any resident that requires a new bracelet for safety purposes will be reported to Engineering by the Charge Nurse. Nursing will test each new Room Alert bracelet before placing on the resident to ensure it functions appropriately. On a weekly basis, Engineering will test the battery on each Room Alert bracelet in use to ensure it functions appropriately.</li> <li>3. a. On 07/31/12, the Engineering staff changed the locking system configuration to be unlocked at all times. As of 07/31/12, all staff can readily exit and evacuate through the unlocked doors.</li> </ol>	08/22/12
F 517 SS=L	<p>483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS</p> <p>The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy and procedures, it was determined the facility failed to have a detailed written plan and procedure to meet all potential emergencies and disasters. The facility's policy and procedure failed to detail the exit door lock down system and did not address the mechanisms utilized to unlock the door (badge/pass code) in the event of an emergency requiring evacuation. The facility's review of the policy dated 01/2012 failed to identify this as a concern. One staff was observed having six minutes of failed attempts to exit the facility; as his badge was not functional. Two staff was observed without their badge having no knowledge of the pass code and were unable to immediately open the door. Interviews with nine staff revealed they were not aware of a pass code to bypass to bypass the locks on the emergency exit doors if their name badges were not available or did not function.</p> <p>A review of the Census and Condition, dated 07/31/12, revealed there were 107 residents in the building.</p>	F 517		

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F 517	<p>Continued From page 78</p> <p>The facility's failure to have a detailed written plan and procedure to address the mechanisms used to unlock emergency exit doors so that facility staff could evacuate residents in the event of an emergency or disaster is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/31/12 and determined to exist on 07/31/12. An acceptable AoC was received on 08/03/12. The AoC was verified on 08/03/12 and it was determined the Immediate Jeopardy was removed on 08/02/12, as alleged in the AoC. The S/S was lowered to a "F", based on the facility's need to continue to evaluate the implementation of changes and quality assurance activities.</p> <p>Findings include:</p> <p>A review of the facility's Emergency Operation Plan and Emergency Management Plan, last reviewed on 01/2012, and review of the Roam Alert System policy and procedure, last revised 06/2007, revealed the plans and policy and procedure did not detail the mechanisms in place to bypass the locked emergency exit doors in the event of an emergency or disaster and the need to evacuate residents.</p> <p>Observation on 07/31/12 between 4:30 PM and 5:00 PM revealed the four emergency exit doors located in the long term care facility were locked and could not be opened.</p> <p>Interview with the Facility Manager, on 07/31/12 at 4:40 PM, revealed the four emergency exit doors on the Long Term Care Unit (buildings 4 and 5) were kept locked and staff was required to</p>	F 517	<p>Continued from page 78</p> <p>The unlocking function using the pass code, ID badge, and Fire Alarm system testing for situations where Roam Alert bracelets locked doors was tested on 07/31/12 by the Engineering staff and were found to function correctly. The ID badge and pass code testing will continue to be checked weekly by the Engineering staff. The fire alarm testing will be continued three times per month thereafter by the Engineering staff.</p> <p>b. Roam Alert and Wandering Risk Precautions policies and procedural guidelines related to mechanisms for exiting/evacuating the building were revised on 07/31/12 by the DON to reflect the use of the pass code, ID Badge, and Fire Alarm system. These revisions were communicated to staff by the DON and Clinical Educator on 07/31/12 and 08/01/12 via email, computerized based learning module, and during return demonstrations by staff. Emergency Management policies and procedural guidelines related to the use a badge swipe, pass code, or fire alarm for evacuation were revised by our Facilities Vice President on 08/20/12. All Emergency Management policies and procedural guideline revisions were communicated to all staff by email on 08/20/12.</p> <p>c. The Clinical Educator developed an in-service program on 07/31/12 to educate staff on the new standardized pass code, badge swipe bypass, and fire alarm bypass methods when needed to unlock the Roam Alert lockdown if activated by a Roam Alert bracelet. The Director of Nursing, Assistant Director of Nursing and the Clinical Educator initiated in-service training 07/31/12.</p>	

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F 517	<p>Continued From page 79</p> <p>utilize their badge or the pass code to unlock the doors for emergency evacuation.</p> <p>An observation of the Facility Manager, on 07/31/12 at 4:30 PM, revealed he attempted to exit the emergency exit door on the north side of building 4 and his badge failed to open the exit door. He tried to enter a pass code but was unable to get the door to open. He tried to use another employee's badge and was able to open the door with the badge. It took approximately six minutes for the Facility Manager to finally exit the building. Interview, on 07/31/12 at 4:40 PM, with the Facility Manager, revealed he was aware the security badge would open the door but he thought the MRI machine must have deleted his badge and caused it not to work. He revealed he did not know the pass code to open the door.</p> <p>Further observation with the Facility Manager, on 07/31/12 at 4:43 PM, revealed Registered Nurse (RN) #1 attempted to exit the north emergency exit door of building 4 without using her employee badge. She attempted to push the door open but was unable to open the door. She did not attempt to enter a pass code to exit the building. The Facility Manager instructed RN #1 to use her employee badge to open the door. RN #1 did not have her employee badge with her as she had left it on her medication cart. She retrieved the badge and was able to unlock the door and exit the building using the badge. Interview, on 08/01/12 at 1:38 PM with RN #1, revealed she was knew her employee badge would open the emergency exit doors. She stated she was trained, when the system was installed several years ago, on how to use the badge to exit the door. She revealed she was not aware of a pass</p>	F 517	<p>Continued from page 79</p> <p>All remaining Long Term Care staff who had not returned to work since 07/31/12 completed their training by 08/21/12. The in-service training also included revisions to the Roam Alert and Wander Risk Precautions policies and procedural guidelines regarding the new standardized pass code.</p> <p>Initial orientation competencies for new hires were revised by the Clinical Educator on 07/31/12 to include the use of the new standardized pass code for the Roam Alert system. All new staff will be in-serviced by the Clinical Educator prior to starting their first scheduled shift. The Clinical Educator will ensure all existing staff demonstrate ongoing competency annually when assigned their annual competencies. Any staff needing a new badge will receive it from Engineering once they have been put into the Roam Alert System and prior to the beginning of their next shift. In the event an employee fails to demonstrate competency in using the badge swipe, pass code, and fire alarm, the employee will be removed from long term care.</p> <p>4. a. Engineering staff initiated the following monitoring starting 07/31/12:</p> <ol style="list-style-type: none"> <li>i. Weekly testing of doors to ensure they remain unlocked and open appropriately.</li> <li>ii. Weekly testing for Roam Alert system to include: <ol style="list-style-type: none"> <li>1. Roam Alert bracelet activation of locking mechanism</li> <li>2. ID badge and pass code bypass to unlock doors when activated by the Roam Alert Bracelet.</li> </ol> </li> </ol>	

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F 517	<p>Continued From page 80</p> <p>code to open the door in case the badge failed to open the door.</p> <p>Continued observation with the Facility Manager, on 07/31/12 at 4:50 PM, revealed Certified Nurse Aide (CNA) #1 did not have her badge and was not aware of a pass code to open and exit the south emergency exit door in building 5. Interview, on 08/01/12 at 2:06 PM with CNA #1, revealed she had not been educated that her employee badge would open the emergency exit doors and had not been educated on a pass code that would open the doors.</p> <p>Continued observation with the Facility Manager, on 07/31/12 at 4:55 PM, revealed Licensed Practical Nurse (LPN) #1, attempted to exit the south emergency exit door of building 5 by swiping her name badge then repeatedly tried to push the door open, unsuccessfully. The Facility Manager had to slam the door hard to get it to open. Interview, on 08/01/12 at 1:30 PM with LPN #1, revealed the only time she was trained on how to use her name badge to open the door was when she was hired back in April 2006. She stated she was not aware the door was stuck and that she had to press harder on the door.</p> <p>Interviews with the Facility Manager, RN #1, RN #2, LPN #1, LPN #7, CNA #1, CNA #12, CNA #15 and CNA #17, on 07/31/12 at 4:30 PM and 4:40 PM, on 08/01/12 at 10:25 AM, 10:30 AM, 10:45 AM, 11:30 AM, 1:30 PM, 1:38 PM and 3:50 PM, respectively, revealed they were not aware of a pass code to bypass the locked emergency exit doors if they did not have their badges or their badges did not function appropriately.</p>	F 517	<p>Continued from page 80</p> <p>lii. Fire alarm testing three times per month to ensure doors will unlock after being activated and locked by the Roam Alert Bracelet.</p> <p>b. The Facilities Manager revised the Hazardous Surveillance tool to monitor staff's ongoing competency monthly using the new standardized pass code. Ongoing annual drills will be performed by Engineering staff to test the evacuation process to ensure staff know how to exit doors. All results of testing, Hazardous Surveillance, and annual evacuation drills will be reported quarterly to the Safety Sub-Committee (Administrator, Facilities Vice President, Corporate Security Officer, Facilities Manager, DON &amp; Clinical Educator). Policy and Procedural guidelines for Roam Alert, Wandering Risk Precautions will be reviewed annually by the DON. Emergency Management policies and procedural guidelines will be reviewed annually by the Safety Sub-Committee. The Facilities Manager will be responsible for ensuring staff's compliance with all processes.</p> <p>5. All corrective actions were completed by 08/22/12.</p>	

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F 517	<p>Continued From page 81</p> <p>Interview with the Clinical Educator, on 08/01/12 at 12:09 PM, revealed he was trained upon his hire on how to operate the emergency exit doors with his employee badge and the pass code system. He stated he thought his employee id number was the pass code, but he was not sure of that. He stated he does the training of the new employees in their orientation.</p> <p>Interview with the Administrator, on 08/01/12 at 2:45 PM, revealed he was not aware the facility's emergency plans and procedures did not address the use of a pass code to ensure staff were able to evacuate residents in the event of an emergency or disaster. He was not aware the staff were not trained on the bypass code for the emergency exit doors. He was aware there were no competency checks completed with staff to ensure they were able to bypass the locked emergency exit doors. He revealed the staff would not be able to open the emergency exit doors timely if the staff did not have functioning name badges or if the alarm system was not functioning appropriately.</p> <p>The facility submitted an acceptable Allegation of Compliance on 08/02/12 which alleged the removal of Immediate Jeopardy on 08/01/12. The State Agency verified Immediate Jeopardy was removed on 08/02/12, through the following review:</p> <p>Interviews with the Vice President of Facilities and the Administrator, on 08/02/12 at 4:25 PM and 4:33 PM, revealed they investigated and determined that the exit doors could be placed in an unlocked status and if the Room Alert Status was activated to lock the doors that staff could</p>	F 517		

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F 517	<p>Continued From page 82</p> <p>use their badge swipe, pass code, or fire alarm to bypass the locking mechanism on 07/31/12.</p> <p>Observations of the emergency exit doors and interview with the Facility Manager, on 08/02/12 at 5:12 PM, revealed: 1) the locking function of the exit doors was changed to being unlocked at all times on 07/31/12. 2) A standardized bypass code was programmed in the exit doors for all staff to use in cases where the Roam Alert system becomes active and there is a need to unlock the door. 3) The Engineering Staff initiated checking to ensure the standardized code would unlock the doors when the Roam Alert system was activated on 07/31/12. This function will continue daily through 08/05/12, then weekly thereafter. 4) the Engineering staff initiated testing of the fire alarm system to ensure the doors were unlocked in cases of fire alarms or power failures. This will continue daily through 08/05/12 and three times a month thereafter. A review of the Fire Alarm Function Monitoring, Pass code Function Monitoring and Badge Swipe Function Monitoring forms revealed the daily checks had been initiated and completed on 08/01/12 and continued.</p> <p>Interview with the Clinical Educator, on 08/02/12 at 5:27 PM, revealed he initiated training of all staff in the building, on 07/31/12, on how to use the badge swipe, new standardized pass code and fire alarm pull station to bypass the Roam Alert locking mechanism. This included the revisions to the Roam Alert and Wander Risk precautions policy and procedural guidelines regarding the standardized pass code. All staff not present would be educated before working their next scheduled shift. He also revealed he</p>	F 517		

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F 517	<p>Continued From page 83</p> <p>updated the new employee orientation on 07/31/12, to include the new standardized pass code. He stated he developed a computer based learning module for ongoing staff competency training. This material was distributed to all staff on 07/31/12 and will be completed by all staff prior to their next scheduled shift. A review of the inservice documentation, dated 07/31/12 and 08/01/12, revealed all staff was trained on how to use the badge swipe, new standardized pass code and fire alarm pull station to bypass the Roam Alert locking mechanism. A review of the Roam Alert System policy and procedure, last revised 07/2012, revealed it was revised to include: to exit the facility by an outside door, swipe your badge and push the door open at the handle, the doors can be deactivated by a badge swipe, entering the pass code, or pulling the fire alarm station to exit and push the door open at the handle, and if you obtain a new badge, notify engineering before working your scheduled shift. Observations and interviews with RN #2, LPN #2, LPN #3, Housekeeper #4 and #6, CNA #3, CNA #8 and a Unit Clerk, on 08/02/12 at 7:00 PM, 7:10 PM, 7:15 PM, and 7:20 PM, and on 08/03/12 at 9:42 AM, 9:47 AM, 9:50 AM and 9:55 AM, respectively, revealed they were able to open the emergency exit doors with their name badges and with the pass code. The staff revealed they received inservicing and computer module training related to exiting the emergency exit doors with their badges, pass code and fire alarm. The staff stated Administration also had them demonstrate that they were able to open the doors with the pass code and name badge.</p> <p>Interview with the Director of Nursing, Assistant</p>	F 517			

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F 517	<p>Continued From page 84</p> <p>Director of Nursing, and Clinical Educator, on 08/02/12 at 12:30 PM, 5:27 PM and 6:27 PM, respectively, revealed all scheduled staff completed a return demonstration competency on how to bypass locked doors prior to working. All remaining employees will do a return demonstration prior to working the next scheduled shift. A review of 2012 Competency Program Attendance Records, dated 08/01/12, revealed all staff demonstrated the use of the name badge and pass code to bypass the roam alert locking mechanism. The Clinical Educator stated he revised the initial competency tool and the Facilities Manager revised the Hazardous Surveillance tool to assess staff's ongoing competency using the new standardized pass code. A review of the Initial Placement Competency Assessment and and Hazard Surveillance Tool revealed the tools included a competency to use employee badge and pass code to bypass the Roam Alert locking mechanism. The staff revealed if an employee failed to demonstrate competency in using the badge swipe, pass code, and fire alarm, the employee will be removed from long term care.</p> <p>Based on the above observations, interviews and documentation reviews, it was determined the Immediate Jeopardy was removed, effective 08/02/12, with the scope and severity lowered to a "F."</p>	F 517		
F 518 SS=L	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using</p>	F 518	<p>F 518 The facility trains all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carries out unannounced staff drills using those procedures.</p>	08/22/12

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F 518	<p>Continued From page 85 those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure and inservices, it was determined the facility failed to train staff when hired on the pass code to bypass the locked emergency exit doors. In addition, the facility failed to periodically review the procedures with staff related to the mechanisms to unlock the emergency exit doors in the event of an emergency or disaster. Observations of four staff revealed they were unable to immediately exit the emergency exit doors using their name badges and were not aware of the pass code to bypass the locked emergency doors. Staff was observed with failing badges on their person and/or no knowledge of the pass code to unlock the exit door. Nine staff had no knowledge of the pass code to open the emergency exit doors in the event they did not have their name badge of the name badge was not functional. Furthermore, the Clinical Educator, who was responsible for training staff, was not knowledgeable of the pass code to unlock the door in the event of an emergency.</p> <p>The facility's failure to train staff related to the mechanisms to bypass the locked emergency exit doors in the event of an emergency or disaster is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/31/12 and determined to exist on 07/31/12. An acceptable AoC was received on 08/03/12. The AoC was verified on 08/03/12 and it was determined the</p>	F 518	<p>Continued from page 85</p> <ol style="list-style-type: none"> <li>On 07/31/12, the Administrator, Director of Nursing, and Facilities Manager identified that all residents may be impacted. Corrective action was taken immediately. All exit doors were unlocked on 07/31/12 by the Engineering staff.</li> <li>On 07/31/12, all residents with Roam Alert bracelets were identified by Engineering staff. Residents wearing the Roam Alert bracelet for safety to prevent elopement were identified as activating the electronic/magnetic lock on exit doors. The bracelet function of each resident was tested by the Engineering staff on 07/31/12 and is tested ongoing on a weekly basis thereafter for correct functioning. Any resident that requires a new bracelet for safety purposes will be reported to Engineering by the Charge Nurse. Nursing will test each new Roam Alert bracelet before placing on the resident to ensure it functions appropriately. On a weekly basis, Engineering will test the battery on each Roam Alert bracelet in use to ensure it functions appropriately.</li> <li>a. On 07/31/12, the Engineering staff changed the locking system configuration to be unlocked at all times. As of 07/31/12, all staff can readily exit and evacuate through the unlocked doors. The unlocking function using the pass code, ID badge, and Fire Alarm system testing for situations where Roam Alert bracelets locked doors was tested on 07/31/12 by the Engineering staff and were found to function correctly. The ID badge and pass code testing will continue to be checked weekly by the Engineering staff. The fire alarm testing will be continued three times per month thereafter by the Engineering staff.</li> </ol>	

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164	
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F 518	<p>Continued From page 86</p> <p>Immediate Jeopardy was removed on 08/02/12, as alleged in the AoC. The S/S was lowered to a "F", based on the facility's need to continue to evaluate the implementation of changes and quality assurance activities.</p> <p>Findings include:</p> <p>Observation, on 07/31/12 at 4:30 PM, with the Facilities Manager and the Administrator, revealed the emergency exit doors at the north and south exits of buildings 4 and 5 were locked and there were Velcro stop signs placed in front of the doors.</p> <p>Interview with the Facility Manager, on 07/31/12 at 4:40 PM, revealed the four emergency exit doors on the Long Term Care Unit (buildings 4 and 5) were kept locked and staff was required to utilize their badge or the pass code to unlock the doors for emergency evacuation. The Facility Manager demonstrated how the doors worked at the northwest exit door. He swiped his badge; however, the badge failed to open the exit door. He then tried to enter a pass code but still could not get the door to open. He got another employee's badge, and was able to open the door with the badge. Approximately six minutes passed during the Facility Manager's attempts to try to unlock the door for exit before he was successful.</p> <p>An interview with the Facility Manager, on 07/31/12 at 4:40 PM, revealed he was aware the security badge would open the door but was not aware of the pass code to open the door.</p> <p>Observation of Registered Nurse (RN) #1, on</p>	F 518	<p>Continued from page 86</p> <p>b. Roam Alert and Wandering Risk Precautions policies and procedural guidelines related to mechanisms for exiting/evacuating the building were revised on 07/31/12 by the DON to reflect the use of the pass code, ID Badge, and Fire Alarm system. These revisions were communicated to staff by the DON and Clinical Educator on 07/31/12 and 08/01/12 via email, computerized based learning module, and during return demonstrations by staff. Emergency Management policies and procedural guidelines related to the use a badge swipe, pass code, or fire alarm for evacuation were revised by our Facilities Vice President on 08/20/12. All Emergency Management policies and procedural guideline revisions were communicated to all staff by email on 08/20/12.</p> <p>c. The Clinical Educator developed an in-service program on 07/31/12 to educate staff on the new standardized pass code, badge swipe bypass, and fire alarm bypass methods when needed to unlock the Roam Alert lockdown if activated by a Roam Alert bracelet. The Director of Nursing, Assistant Director of Nursing and the Clinical Educator initiated in-service training 07/31/12. All remaining Long Term Care staff who had not returned to work since 07/31/12 completed their training by 08/21/12. The in-service training also included revisions to the Roam Alert and Wander Risk Precautions policies and procedural guidelines regarding the new standardized pass code.</p>	

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F 518	<p>Continued From page 87</p> <p>07/31/12 at 4:43 PM, revealed she came to the exit door without her employee badge. She tried several times to push the door open; however, she did not try to enter a pass code or use her badge to exit the building. The Facilities Manager told RN #1 to use her employee badge. She retrieved the badge from her medication cart and was then able to exit the building.</p> <p>Interview with RN #1, on 08/01/12 at 1:38 PM, revealed she was aware that she needed to have her badge to exit the building. She stated it had been a while since she had any kind of training on the exit doors. She was trained briefly when the system was installed on how to use the badge to exit the door but was unaware of a pass code to open the door in case the badge failed to open the door.</p> <p>Observation of Certified Nurse Aide (CNA) #1, on 07/31/12 at 4:50 PM, revealed she was unable to open the exit doors and did not try to operate the exit door at the South West exit. Interview with CNA #1, on 08/01/12 at 2:06 PM, revealed she was unaware of how to open the door using her badge or the pass code. She stated she was unaware the badge was required to open the exit doors.</p> <p>Observation of Licensed Practical Nurse #1, on 07/31/12 at 4:53 PM, revealed she walked up to the exit door, swiped her badge at the reader and then tried several times to push the door open. Once she stopped trying, the Facility Manager had to slam hard on the door to get it to open. Interview with LPN #1, on 08/01/12 at 10:25 AM and 1:30 PM, revealed she was aware to use her badge to exit the building. She stated she was</p>	F 518	<p>Continued from page 87</p> <p>Initial orientation competencies for new hires were revised by the Clinical Educator on 07/31/12 to include the use of the new standardized pass code for the Roam Alert system. All new staff will be in-serviced by the Clinical Educator prior to starting their first scheduled shift. The Clinical Educator will ensure all existing staff demonstrate ongoing competency annually when assigned their annual competencies. Any staff needing a new badge will receive it from Engineering once they have been put into the Roam Alert System and prior to the beginning of their next shift. In the event an employee fails to demonstrate competency in using the badge swipe, pass code, and fire alarm, the employee will be removed from long term care.</p> <p>4. a. Engineering staff initiated the following monitoring starting 07/31/12:</p> <ol style="list-style-type: none"> <li>i. Weekly testing of doors to ensure they remain unlocked and open appropriately.</li> <li>ii. Weekly testing for Roam Alert system to include: <ol style="list-style-type: none"> <li>1. Roam Alert bracelet activation of locking mechanism</li> <li>2. ID badge and pass code bypass to unlock doors when activated by the Roam Alert Bracelet.</li> <li>iii. Fire alarm testing three times per month to ensure doors will unlock after being activated and locked by the Roam Alert Bracelet.</li> </ol> </li> </ol>		

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F 518	<p>Continued From page 88</p> <p>trained on this during her new hire orientation back in April of 2006. She did not know that the door was stuck and that she just needed to press harder on the door. She stated there had been no training since her hire date on exiting the building through the egress doors. She further revealed she was unaware of the pass code to unlock the exit door.</p> <p>Interview with RN #2, LPN #7, CNA #15, CNA #17 and CNA #12, on 08/01/12 at 10:25 AM, 10:30 AM, 10:45 AM, 11:30 AM and 3:50 PM, respectively, revealed the staff was not aware of a code to open the emergency exit doors in case their badges did not work. CNA #12 had no recollection of an inservice on how to exit the door prior to the inservice on 07/31/12. RN #2 stated she was only aware that swiping the badge should allow you access to exit the doors and stated the facility had yearly inservices.</p> <p>Interview with the Director of Nursing, on 08/02/12 at 11:30 AM, revealed she was the Clinical Educator when the locked down system was placed on the emergency exit doors of the facility. She stated staff was trained on the use of their badges to bypass the locked doors when the system was initiated. She stated she thought another mechanism to bypass the doors was staff could punch in their employee identification numbers, but she was not sure if the employees were ever made aware of their identification numbers. The only inservicing she was aware of was conducted when the system was installed and when new staff were hired. She was not aware of any periodic training with staff related to using their name badges and pass codes to exit the building through the emergency exit doors.</p>	F 518	<p>Continued from page 88</p> <p>b. The Facilities Manager revised the Hazardous Surveillance tool to monitor staff's ongoing competency monthly using the new standardized pass code. Ongoing annual drills will be performed by Engineering staff to test the evacuation process to ensure staff know how to exit doors. All results of testing, Hazardous Surveillance, and annual evacuation drills will be reported quarterly to the Safety Sub-Committee (Administrator, Facilities Vice President, Corporate Security Officer, Facilities Manager, DON &amp; Clinical Educator). Policy and Procedural guidelines for Roam Alert, Wandering Risk Precautions will be reviewed annually by the DON. Emergency Management policies and procedural guidelines will be reviewed annually by the Safety Sub-Committee. The Facilities Manager will be responsible for ensuring staff's compliance with all processes.</p> <p>5. All corrective actions were completed by 08/22/12.</p>	

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F 518	Continued From page 89  Interview with the Clinical Educator, on 08/01/12 at 12:09 PM, revealed he was trained upon his hire in 2009 on how to operate the exit doors with his employee badge and the pass code system. He stated he thought his employee identification number was the pass code, but he was not sure of that and he did not recall if he was given his employee identification number. He stated he does the training of the new employees in their orientation but has never given them their employee identification number. He also stated the only training completed with staff related to exiting the emergency exit door was during orientation when staff were hired. Further interview revealed when he trained employees during the training yesterday he identified there were some employee badges that did not open the emergency exit doors.  Interview with the Administrator, on 08/01/12 at 3:44 PM, revealed the education staff trained new hires on the use of their identification badges to bypass the locked emergency exits at employee orientation. He was not aware of any ongoing education related to the use of the identification badges or pass code to exit the building.  The facility submitted an acceptable Allegation of Compliance on 08/02/12 which alleged the removal of Immediate Jeopardy on 08/01/12. The State Agency verified Immediate Jeopardy was removed on 08/02/12, through the following review:  Interview with the Vice President of Facilities and the Administrator, on 08/02/12 at 4:25 PM and 4:33 PM, revealed they investigated and	F 518			

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F 518	<p>Continued From page 90</p> <p>determined that the exit doors could be placed in an unlocked status and if the Roam Alert Status was activated to lock the doors that staff could use their badge swipe, pass code, or fire alarm to bypass the locking mechanism on 07/31/12.</p> <p>Observations of the emergency exit doors and interview with the Facility Manager, on 08/02/12 at 5:12 PM, revealed: 1) the locking function of the exit doors was changed to being unlocked at all times on 07/31/12. 2) A standardized bypass code was programmed in the exit doors for all staff to use in cases where the Roam Alert system becomes active and there is a need to unlock the door. 3) The Engineering Staff initiated checking to ensure the standardized code would unlock the doors when the Roam Alert system was activated on 07/31/12. This function will continue daily through 08/05/12, then weekly thereafter. 4) the Engineering staff initiated testing of the fire alarm system to ensure the doors were unlocked in cases of fire alarms or power failures. This will continue daily through 08/05/12 and three times a month thereafter. A review of the Fire Alarm Function Monitoring, Pass code Function Monitoring and Badge Swipe Function Monitoring forms revealed the checks were completed daily from 08/01/12 to 08/03/12 (last day of survey).</p> <p>Interview with the Clinical Educator, on 08/02/12 at 5:27 PM, revealed he initiated training of all staff in the building, on 07/31/12, on how to use the badge swipe, new standardized pass code and fire alarm pull station to bypass the Roam Alert locking mechanism. This included the revisions to the Roam Alert and Wander Risk precautions policies and procedural guidelines</p>	F 518			

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F 518	Continued From page 91 regarding the standardized pass code. All staff not present would be educated before working their next scheduled shift. He also revealed he updated the new employee orientation, on 07/31/12, to include the new standardized pass code. He stated he developed a computer based learning module for ongoing staff competency training. This material was distributed to all staff on 07/31/12 and will be completed by all staff prior to their next scheduled shift. A review of the inservice documentation, dated 07/31/12 and 08/01/12, revealed all staff were trained on how to use the badge swipe, new standardized pass code and fire alarm pull station to bypass the Roam Alert locking mechanism. A review of the Roam Alert System policy and procedure, last revised 07/2012, revealed it was revised to include to exit the facility by an outside door, swipe you badge and push the door open at the handle, the doors can be deactivated by a badge swipe, entering the pass code, or pulling the fire alarm station to exit and push the door open at the handle, and if you obtain a new badge, notify engineering before working your scheduled shift. Observations and interviews with RN #2, LPN #2, LPN #3, Housekeeper #4 and #6, CNA #3, CNA #8 and a Unit Clerk, on 08/02/12 at 7:00 PM, 7:10 PM, 7:15 PM, and 7:20 PM, and on 08/03/12 at 9:42 AM, 9:47 AM, 9:50 AM and 9:55 AM, respectively, revealed they were able to open the emergency exit doors with their name badges and with the pass code. The staff revealed they received inservicing and computer module training related to exiting the emergency exit doors with their badges, pass code and fire alarm. The staff stated Administration also had them demonstrate that they were able to open the doors with the pass	F 518			

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F 518	Continued From page 92 code and name badge.  Interview with the Director of Nursing, Assistant Director of Nursing, and Clinical Educator, on 08/02/12 at 12:30 PM, 5:27 PM and 6:27 PM, respectively, revealed all scheduled staff completed a return demonstration competency on how to bypass locked doors prior to working. All remaining employees will do a return demonstration prior to working the next scheduled shift. A review of 2012 Competency Program Attendance Records, dated 08/01/12, revealed all staff demonstrated the use of the name badge and pass code to bypass the roam alert locking mechanism. The Clinical Educator stated he revised the initial competency tool and the Facilities Manager revised the Hazardous Surveillance tool to assess staff's ongoing competency using the new standardized pass code. A review of the Initial Placement Competency Assessment and and Hazard Surveillance Tool revealed the tools included a competency to use employee badge and pass code to bypass the Roam Alert locking mechanism. The staff revealed if an employee failed to demonstrate competency in using the badge swipe, pass code, and fire alarm, the employee will be removed from long term care.  Based on the above observations, interviews and documentation reviews, it was determined the Immediate Jeopardy was removed, effective 08/02/12, with the scope and severity lowered to a "F."	F 518			

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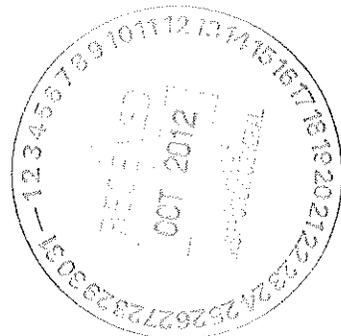
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/03/2012
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K 000	<p>INITIAL COMMENTS</p> <p>AMENDED 08/24/12 INITIAL COMMENTS TO INCLUDE IMMEDIATE JEOPARDY DESCRIPTION</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/31/12 thru 08/03/12. Cal Turner Extended Care Pavilion was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey.</p>	K 000	<p>This plan of correction is offered as an attempt to provide the highest level of quality services possible to the residents at Cal Turner Rehab and Specialty Care and is not an admission that the deficiencies cited are correct.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 10/02/12
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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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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 458 BURNLEY RD. SCOTTSVILLE, KY 42164		
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K 000	Continued From page 1  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).  Based on observation and interview, it was determined the facility failed to ensure egress was maintained at all exit doors in accordance with NFPA standards. The deficient practice affected four (4) of four (4) smoke compartments affecting all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey. The facility failed to ensure that staff was knowledgeable of the existing exit door system and failed to ensure staff was equipped with functional badges and/or passcode to readily unlock exit doors for means of egress at all times. On 07/31/12, all four exit doors of the nursing facility were maintained in lock down mode which prevented a person from being able to exit the door without having a badge or having a passcode. Staff (Facility Manager, Registered Nurse (RN) #1, Certified Nurse Aide (CNA) #1, Licensed Practical Nurse (LPN) #1) was observed unable to exit through the fire exit doors that were in lock down mode in order to effectively evacuate residents in the event of an emergency. Additionally, the Clinical Educator who is responsible for training new hires was unaware of what the passcode was to unlock the doors. Furthermore, the facility failed to have a system developed and implemented to ensure staff badges were functional to operate the exit doors in the event of an emergency requiring evacuation.	K 000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/03/2012
NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164	
(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 2 The facility's failure to ensure the staff could readily unlock the nursing facility's four exit doors for means of egress at all times created a condition that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/31/12, determined to exist on 07/31/12 and was removed on 08/02/12. Deficiencies were cited with the highest deficiency identified at "L" level. After immediate jeopardy was cleared the highest deficiency cited was at an "F" level.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by:	K 018	<b>K 018</b> The facility ensures doors to resident rooms would latch properly in accordance with NFPA standards. 1. On 07/31/12, the Facilities Manager identified impacted residents in rooms B13, B15, B21, and B24. The Facilities Manager assigned work orders on 07/31/12 to Engineering staff for repairs to the doors. As of 07/31/12, all doors to these rooms latch properly. 2. On 07/31/12, all other resident's door latches were inspected and repaired as needed by Engineering staff. Following repairs, doors to all resident rooms latched properly. 3. Starting 08/21/12, the Facility Manager assigned work orders for engineering staff to check all door latches monthly. Engineering staff will use a checklist and work orders to document completion of inspections and any corrections. 4. Starting 08/21/12, the Facilities Manager will monitor ongoing completion of the checklists, work orders, and preventive maintenance assignments monthly. In addition to monthly inspections, Engineering staff will monitor doors latching shut when closed during fire alarm and severe weather drills. This item has been added to the fire alarm and severe weather surveillance checklists. 5. All corrective actions were completed by 08/23/12.	08/23/12

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSDALE, KY 42164	
(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 018	<p>Continued From page 3</p> <p>Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, 8 residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey. The facility failed to ensure the corridor doors to the resident rooms in Building 4 were latching properly.</p> <p>The findings include:</p> <p>Observations, on 07/31/12 between 1:00 PM and 4:30 PM with the Facilities Manager, revealed the corridor doors to rooms B15, B13, B24, and B21 would not latch properly.</p> <p>Interviews, on 07/31/12 between 1:00 PM and 4:30 PM with the Facilities Manager, confirmed the observation of the doors not latching and revealed he was unaware these doors were not latching properly. The Facilities Manager was aware that all resident room doors must latch in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall</p>	K 018		

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164	
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K 018	Continued From page 4 not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029	<i>K 029 Facility meets the standard for Protection of Hazards in accordance with NFPA standards.</i> 1. On 08/01/12, the Facilities Manager identified that 33 residents were impacted. On 08/22/12, Engineering staff placed door closers on both of the Kitchen storage rooms in the dining room, the clean linen storage in building 4, and the MDS office. 2. On 08/01/12, the Facilities Manager and Engineering staff completed inspections for all areas with storage of combustibles to ensure doors had closers installed. The chemicals stored in the room by the dish room were removed. No other areas were identified as needing door closers installed. Consequently, no other residents were impacted.	08/23/12

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42184	
(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 029	Continued From page 5 permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, 33 residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey. The facility failed to ensure four (4) rooms were properly protected due to the storage in the rooms.  The findings include:  Observation, on 07/31/12 and 08/01/12 between 1:00 PM and 4:30 PM both days with the Facilities Director, revealed both of Kitchen storage rooms in the dining room, the storage room in the dish washing area, the clean linen storage in building 4, and the MDS office need a closer added to the door due to the storage of combustibles inside the areas.  Interview, on 07/31/12 and 08/01/12 between 1:00 PM and 4:30 PM both days with the Facilities Director, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.  Reference:	K 029	Continued from page 5  3. Starting 08/21/12, Engineering staff were assigned ongoing quarterly inspections for all areas with door closers to ensure they function correctly. 4. Starting 08/21/12, the Facilities Manager will monitor completion of the staff's assigned inspection logs on a quarterly basis. 5. All corrective actions were completed by 08/23/12	

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 466 BURNLEY RD. SCOTTSVILLE, KY 42164	
(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 029	Continued From page 6  NFPA 101 (2000 Edition).  19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038	K 038 The facility has Exit access arranged so that exits are readily accessible at all times in accordance with NFPA 101 Life Safety Code Standards .	08/22/12

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K 038 SS=L	Continued From page 7  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress was maintained at all exit doors in accordance with NFPA standards. The deficient practice affected four (4) of four (4) smoke compartments affecting all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey. The facility failed to ensure that staff was knowledgeable of the existing exit door system and failed to ensure staff was equipped with functional badges and/or passcode to readily unlock exit doors for means of egress at all times. On 07/31/12, all four exit doors of the nursing facility were maintained in lock down mode which prevented a person from being able to exit the door without having a badge or having a passcode. Staff (Facility Manager, Registered Nurse (RN) #1, Certified Nurse Aide (CNA) #1, Licensed Practical Nurse (LPN) #1) was observed unable to exit through the fire exit doors that were in lock down mode in order to effectively evacuate residents in the event of an emergency. Additionally, the Clinical Educator who is responsible for training new hires was	K 038	Continued from page 7  1. On 07/31/12, the Administrator, Director of Nursing, and Facilities Manager identified that all residents may be impacted. Corrective action was taken immediately. All exit doors were unlocked on 07/31/12 by the Engineering staff. 2. On 07/31/12, all residents with Roam Alert bracelets were identified by Engineering staff. Residents wearing the Roam Alert bracelet for safety to prevent elopement were identified as activating the electronic/magnetic lock on exit doors. The bracelet function of each resident was tested by the Engineering staff on 07/31/12 and is tested ongoing on a weekly basis thereafter for correct functioning. Any resident that requires a new bracelet for safety purposes will be reported to Engineering by the Charge Nurse. Nursing will test each new Roam Alert bracelet before placing on the resident to ensure it functions appropriately. On a weekly basis, Engineering will test the battery on each Roam Alert bracelet in use to ensure it functions appropriately.	

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K 038	<p>Continued From page 8</p> <p>unaware of what the passcode was to unlock the doors. Furthermore, the facility failed to have a system developed and implemented to ensure staff badges were functional to operate the exit doors in the event of an emergency requiring evacuation.</p> <p>The facility's failure to ensure the staff could readily unlock the nursing facility's four exit doors for means of egress at all times created a condition that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/31/12, determined to exist on 07/31/12 and was removed on 08/02/12.</p> <p>The findings include:</p> <p>Interview, on 07/31/12 at 4:40 PM with the Facility Manager, revealed the four exit doors were set for lockdown (delayed egress at the lock position) and staff was required to utilize their badge or the passcode to unlock the doors for emergency evacuation. However, review of the facility's emergency management plan and the emergency operations plan revealed neither plan addressed the exit doors, the system being set to lock down nor procedures to get the doors unlocked.</p> <p>Observation and record review, on 07/31/12 between 4:30 PM and 5:00 PM with the Facilities Manager and the Administrator, revealed the egress doors at building 4 north and south exits and building 5 north and south exits were locked and could not be opened. Further observation revealed there were Velcro stop signs placed in front of each of these egress doors. The Facility Manager demonstrated how the doors worked at the building 4 north exit door; however, during the</p>	K 038	<p>Continued from page 8</p> <p>3.a. On 07/31/12, the Engineering staff changed the locking system configuration to be unlocked at all times. As of 07/31/12, all staff can readily exit and evacuate through the unlocked doors. The unlocking function using the pass code, ID badge, and Fire Alarm system testing for situations where Roam Alert bracelets locked doors was tested on 07/31/12 by the Engineering staff and were found to function correctly. The ID badge and pass code testing will continue to be checked weekly by the Engineering staff. The fire alarm testing will be continued three times per month thereafter by the Engineering staff.</p> <p>b. Roam Alert and Wandering Risk Precautions policies and procedural guidelines related to mechanisms for exiting/evacuating the building were revised on 07/31/12 by the DON to reflect the use of the pass code, ID Badge, and Fire Alarm system. These revisions were communicated to staff by the DON and Clinical Educator on 07/31/12 and 08/01/12 via email, computerized based learning module, and during return demonstrations by staff. Emergency Management policies and procedural guidelines related to the use a badge swipe, pass code, or fire alarm for evacuation were revised by our Facilities Vice President on 08/20/12. All Emergency Management policies and procedural guideline revisions were communicated to all staff by email on 08/20/12.</p>	

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K 038	<p>Continued From page 9</p> <p>demonstration his badge failed to open the exit door. He then tried to enter a passcode but still could not get the door to open. He retrieved another employee's badge and was then able to open the door with the badge. Six minutes passed while the Facility Manager was trying to exit the building, unsuccessfully. Interview, on 07/31/12 at 4:40 PM with the Facility Manager, revealed he was aware the security badge would open the door but was unaware of the passcode to open the door. He stated the MRI machine could have deleted his badge causing it to not function.</p> <p>Continued observation with the Facility Manager, on 07/31/12 between 4:30 PM and 5:00 PM, revealed that RN #1 came to the building 4 north exit door without her employee badge; she attempted to push the door open but was unable to open the door. She did not try to enter a pass code or use her badge to exit the building. The Facilities Manager was observed instructing RN #1 to use her employee badge. RN #1 was observed having no badge on her person and having to retrieve the badge from her medication cart. Using the badge, she was able to unlock the door and exit the building. Interview, on 08/01/12 at 1:38 PM with RN #1, revealed she was aware that she needed to have her badge to exit the building. She stated it had been a while since she had any kind of in-servicing on the exit doors. She was trained briefly when the system was installed on how to use the badge to exit the door but was unaware of a passcode to open the door in case the badge failed to open the door.</p>	K 038	<p>Continued from page 9</p> <p>c. The Clinical Educator developed an in-service program on 07/31/12 to educate staff on the new standardized pass code, badge swipe bypass, and fire alarm bypass methods when needed to unlock the Roam Alert lockdown if activated by a Roam Alert bracelet. The Director of Nursing, Assistant Director of Nursing and the Clinical Educator initiated in-service training 07/31/12. All remaining Long Term Care staff who had not returned to work since 07/31/12 completed their training by 08/21/12. The in-service training also included revisions to the Roam Alert and Wander Risk Precautions policies and procedural guidelines regarding the new standardized pass code. Initial orientation competencies for new hires were revised by the Clinical Educator on 07/31/12 to include the use of the new standardized pass code for the Roam Alert system. All new staff will be in-serviced by the Clinical Educator prior to starting their first scheduled shift. The Clinical Educator will ensure all existing staff demonstrate ongoing competency annually when assigned their annual competencies. Any staff needing a new badge will receive it from Engineering once they have been put into the Roam Alert System and prior to the beginning of their next shift. In the event an employee fails to demonstrate competency in using the badge swipe, pass code, and fire alarm, the employee will be removed from long term care.</p>		

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K 038	<p>Continued From page 10</p> <p>Continued observation with the Facility Manager, on 07/31/12 between 4:30 PM and 5:00 PM, revealed CNA #1 was unable to open the building 4 south exit door. She did not have a badge and was unaware of a passcode so she simply said she could not open the exit door. Interview, on 08/01/12 at 2:06 PM with CNA #1, revealed she was unaware of how to open the door using her badge or the passcode. She stated she was unaware the badge was required to open the exit doors.</p> <p>Continued observation with the Facility Manager, on 07/31/12 between 4:30 PM and 5:00 PM, revealed LPN #1, when asked to demonstrate how to open the exit door at the building 5 south exit, she walked up to the exit, swiped her badge at the reader and then tried several times to push the door open, unsuccessfully. Once she stopped trying the Facility Manager was observed having to slam hard on the door to get it to open. Interview, on 08/01/12 at 1:30 PM with LPN 1, revealed she was aware to use her badge to exit the building. She stated she was trained on this during her new hire orientation back in April of 2006. She did not know that the door was stuck and that she just needed to press harder on the door. She stated there had been no training since her hire date on exiting the building through the egress doors.</p> <p>Interview, on 08/01/12 at 12:09 PM with the Clinical Educator, revealed he was trained upon his hire of how to operate the exit doors with his employee badge and the passcode system. He stated he thought his employee id number was</p>	K 038	<p>Continued from page 10</p> <p>4. a. Engineering staff initiated the following monitoring starting 07/31/12:</p> <ul style="list-style-type: none"> <li>i. Weekly testing of doors to ensure they remain unlocked and open appropriately.</li> <li>ii. Weekly testing for Roam Alert system to include:                             <ul style="list-style-type: none"> <li>1. Roam Alert bracelet activation of locking mechanism</li> <li>2. ID badge and pass code bypass to unlock doors when activated by the Roam Alert Bracelet.</li> <li>iii. Fire alarm testing three times per month to ensure doors will unlock after being activated and locked by the Roam Alert Bracelet.</li> </ul> </li> <li>b. The Facilities Manager revised the Hazardous Surveillance tool to monitor staff's ongoing competency monthly using the new standardized pass code. Ongoing annual drills will be performed by Engineering staff to test the evacuation process to ensure staff know how to exit doors. All results of testing, Hazardous Surveillance, and annual evacuation drills will be reported quarterly to the Safety Sub-Committee (Administrator, Facilities Vice President, Corporate Security Officer, Facilities Manager, DON &amp; Clinical Educator). Policy and Procedural guidelines for Roam Alert, Wandering Risk Precautions will be reviewed annually by the DON. Emergency Management policies and procedural guidelines will be reviewed annually by the Safety Sub-Committee.</li> </ul> <p>5. All corrective actions were completed by 08/22/12.</p>	

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 466 BURNLEY RD. SCOTTSVILLE, KY 42184	
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K 038	<p>Continued From page 11</p> <p>the passcode but he was not sure of that. He stated he does the training of the new employees in their orientation. Further interview revealed during the in-servicing of the employees during the immediate jeopardy some of the employee badges did not open the emergency exit doors. Record review revealed the facility could provide no evidence of a system developed and implemented to ensure staff badges were functional to unlock the egress exit doors.</p> <p>Interview, on 08/01/12 at 3:44 PM with the Administrator, revealed the education staff instructs new hires on the use of badges at employee orientation. He also stated an outside company was hired to assess the locking of the doors. He stated they thought they were in compliance using section 19.2.2.2.4 of NFPA 101.</p> <p>The facility submitted an acceptable Allegation of Compliance on 08/02/12 which alleged the removal of Immediate Jeopardy on 08/01/12. The State Agency verified Immediate Jeopardy was removed on 08/02/12, through the following review:</p> <p>Interviews with the Vice President of Facilities and the Administrator, on 08/02/12 at 4:25 PM and 4:33 PM revealed they investigated and determined that the exit doors could be placed in an unlocked status and if the Roam Alert Status was activated to lock the doors that staff could use their badge swipe, pass code, or fire alarm to bypass the locking mechanism on 07/31/12.</p> <p>Observations of the emergency exit doors and interview with the Facility Manager, on 08/02/12 at 5:12 PM, revealed: 1) the locking function of</p>	K 038		

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K 038	<p>Continued From page 12</p> <p>the exit doors was changed to being unlocked at all times on 07/31/12. 2) A standardized bypass code was programmed in the exit doors for all staff to use in cases where the Roam Alert system becomes active and there is a need to unlock the door. 3) The Engineering Staff initiated checking to ensure the standardized code would unlock the doors when the Roam Alert system was activated on 07/31/12. This function will continue daily through 08/05/12, then weekly thereafter. 4) the Engineering staff initiated testing of the fire alarm system to ensure the doors were unlocked in cases of fire alarms or power failures. This will continue daily through 08/05/12 and three times a month thereafter. A review of the Fire Alarm Function Monitoring, Pass code Function Monitoring and Badge Swipe Function Monitoring forms revealed the daily checks were initiated and completed on 08/01/12 and continued daily.</p> <p>Interview with the Clinical Educator, on 08/02/12 at 5:27 PM, revealed he initiated training of all staff in the building, on 07/31/12, on how to use the badge swipe, new standardized pass code and fire alarm pull station to bypass the Roam Alert locking mechanism. This included the revisions to the Roam Alert and Wander Risk precautions policy and procedural guidelines regarding the standardized pass code. All staff not present would be educated before working their next scheduled shift. He also revealed he updated the new employee orientation on 07/31/12, to include the new standardized pass code. He stated he developed a computer based learning module for ongoing staff competency training. This material was distributed to all staff on 07/31/12 and will be completed by all staff</p>	K 038			

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K 038	<p>Continued From page 13</p> <p>prior to their next scheduled shift. A review of the in-service documentation, dated 07/31/12 and 08/01/12, revealed all staff was trained on how to use the badge swipe, new standardized pass code and fire alarm pull station to bypass the Roam Alert locking mechanism. A review of the Roam Alert System policy and procedure, last revised 07/2012, revealed it was revised to include to exit the facility by an outside door, swipe your badge and push the door open at the handle, the doors can be deactivated by a badge swipe, entering the pass code, or pulling the fire alarm station to exit and push the door open at the handle, and if you obtain a new badge, notify engineering before working your scheduled shift. Observations and interviews with RN #2, LPN #2, LPN #3, Housekeeper #4 and #6, CNA #3, CNA #8 and a Unit Clerk, on 08/02/12 at 7:00 PM, 7:10 PM, 7:15 PM, and 7:20 PM, and on 08/03/12 at 9:42 AM, 9:47 AM, 9:50 AM and 9:55 AM respectively, revealed they were able to open the emergency exit doors with their name badges and with the passcode. The staff revealed they received in-servicing and computer module training related to exiting the emergency exit doors with their badges, passcode and fire alarm. The staff stated Administration also had them demonstrate that they were able to open the doors with the passcode and name badge.</p> <p>Interview with the Director of Nursing, Assistant Director of Nursing, and Clinical Educator, on 08/02/12 at 12:30 PM, 5:27 PM and 6:27 PM revealed all scheduled staff completed a return demonstration competency on how to bypass locked doors prior to working. All remaining employees will do a return demonstration prior to working the next scheduled shift. A review of</p>	K 038			

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K 038	<p>Continued From page 14</p> <p>2012 Competency Program Attendance Records, dated 08/01/12, revealed all staff demonstrated the use of the name badge and pass code to bypass the roam alert locking mechanism. The Clinical Educator stated he revised the initial competency tool and the Facilities Manager revised the Hazardous Surveillance tool to assess staff's ongoing competency using the new standardized pass code. A review of the Initial Placement Competency Assessment and Hazard Surveillance Tool revealed the tools included a competency to use employee badge and pass code to bypass the Roam Alert locking mechanism. The staff revealed if an employee failed to demonstrate competency in using the badge swipe, pass code, and fire alarm, the employee will be removed from long term care.</p> <p>Based on the above observations, interviews and documentation reviews, it was determined the Immediate Jeopardy was removed, effective 08/02/12, with the scope and severity lowered to a "F."</p> <p>NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)</p>	K 038			

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K 038	Continued From page 15 Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey. The facility failed to ensure the fire drills on second and third shift were conducted at random times.  The findings include:	K 050	<i>K 050 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift in accordance with NFPA 101 Life Safety Code Standards.</i>  1. On 07/31/12, the Facilities Manager identified all residents that may be impacted. On 08/01/12, the Facilities Manager re-educated all engineering staff to conduct ongoing Fire alarm drills at least monthly on each shift and at unexpected times under varied conditions on all shifts. 2. On 07/31/12, the Facilities Manager identified that all residents may be impacted. 3. On 08/21/12, the Facilities Manager modified the emphasis of the current schedule for ongoing Fire alarm drills to be conducted at least monthly on each shift and at random ("unexpected") times under varied conditions on all shifts. 4. Starting 08/21/12, the Facilities Manager will monitor ongoing fire alarm drills are conducted at least monthly on each shift and at unexpected times under varied conditions on all shifts. Starting 08/21/12, the Facilities Manager will report this information to the Medical Center's Safety Sub-committee (Administrator, Facilities Vice President/ Corporate Security Officer, Facilities Manager, DON & Clinical Educator). 5. All corrective actions were completed by 08/22/12	08/22/12

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K 050	Continued From page 16 Fire Drill review, on 07/31/12 at 12:30 PM with the Facilities Manager, revealed the fire drills were not being conducted at random times on second and third shift. Fire drills on second shift were conducted routinely between 7:20 PM and 9:20 PM and third shift routinely between 5:50 AM and 6:40 AM.  Interview, on 07/31/12 at 12:30 PM with the Facilities Manager, revealed he was unaware the fire drills were not being conducted as required. The Facilities Manager was unaware of the time separation on each shift to consider the times unexpected.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred	K 062	<b>K 062 Automatic Sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically in accordance with NFPA 101 Life Safety Codes.</b>  1. On 07/31/12, the Facilities Manager identified that all residents may be impacted. On 08/02/12, the sprinkler riser gauges were replaced and calibrated by Eagle Sprinkler Company. The internal components of the system were inspected as well. 2. On 07/31/12, the Facilities Manager identified that all residents may be impacted. 3. On 08/21/12, the Facilities Manager implemented scheduled maintenance reminders for the sprinkler riser system inspections in the facility's work tracking system (ISIS Pro) and also in Microsoft Outlook Calendar. 4. Effective 08/21/12, the Facilities Manager will provide ongoing monitoring of compliance with scheduled sprinkler riser system inspections. Effective 08/21/12, the Facilities Manager will report all sprinkler riser system inspections to the Safety Sub-Committee (Administrator, Facilities Vice President, Corporate Security Officer, Facilities Manager, DON & Clinical Educator). 5. All corrective actions were completed by 08/22/12.	08/22/12

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K 062	<p>Continued From page 17</p> <p>seven (107) on the day of the survey. The facility failed to ensure the inside of the sprinkler piping and the gauges on the sprinkler riser were inspected every five (5) years.</p> <p>The findings include:</p> <p>Observation and record review, on 07/31/12 at 11:51 AM with the Facilities Manager, revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last 5 years.</p> <p>Interview, on 07/31/12 at 11:51 AM with the Facilities Manager, revealed he was not aware the gauges on the sprinkler riser had to be calibrated or replaced once every 5 years.</p> <p>Observation and record review, on 07/31/12 at 11:53 AM with the Facilities Manager, revealed the sprinkler system had no internal inspection within the last 5 years. Further observation showed the last internal pipe inspection was performed on 03/29/07.</p> <p>Interview, on 07/31/12 at 11:53 AM with the Facilities Manager, revealed he was aware the internal pipe inspection was to be performed every five (5) years but he was unaware the last inspection was over five (5) years ago..</p> <p>Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not</p>	K 062			

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K 062	<p>Continued From page 18</p> <p>been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1</p>	K 062		

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K 062	Continued From page 19 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	<b>N 064</b> Portable fire extinguishers are provided in all health care occupancies and maintained in accordance with NFPA 101 Life Safety Codes.  1. On 07/31/12, the Facilities Manager identified that 33 residents of building 4 may be impacted. On 08/01/12 Engineering staff completed the lowering of all extinguishers (including kitchen, employee break room, and mechanical room in building 4) to be below 60 inches in height from the floor to the top of the extinguisher. On 08/02/12, Engineering staff installed signage for the Class K extinguisher in the kitchen.	08/22/12

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K 064	<p>Continued From page 20</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers per NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, 33 residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey. The facility failed to ensure the fire extinguishers in the kitchen area and the mechanical rooms in Building 4 were properly mounted as well as proper signage for the class k extinguisher in the kitchen.</p> <p>Findings include:</p> <p>Observations, on 07/31/12 and 08/01/12 between 1:00 PM and 4:30 PM with the Facilities Manager, revealed the wall mounted, portable fire extinguishers located in the kitchen, employee break room, and the mechanical room in building 4, were mounted above the maximum allowable height of five (5) feet above the finish floor.</p> <p>Interview, on 07/31/12 and 08/01/12 between 1:00 PM and 4:30 PM with the Facilities Manager, revealed that he was unaware of the height limitations for wall mounted portable fire extinguishers and acknowledged that they were mounted above the height of five (5) feet above the finish floor.</p> <p>Observation, on 08/01/12 between 1:00 PM and 4:30 PM with the Facilities Manager, revealed there was no signage stating that the hood</p>	K 064	<p>Continued from page 20</p> <p>2. On 07/31/12, the Facilities Manager and Engineering staff identified that no other residents were impacted. As of 08/02/12, Engineering staff inspected all extinguishers to ensure extinguisher class signage was correct and the extinguishers were at the appropriate height of less than 60 inches from the floor.</p> <p>3. Effective 08/21/12, Engineering staff will inspect fire extinguishers monthly to ensure the appropriate extinguisher class signage is correct and the extinguishers are at the appropriate height of less than 60 inches. On 08/21/12, the Facilities Manager instructed Booth Fire and Safety, our fire extinguisher contractor, to inspect fire extinguishers semi-annually to ensure the appropriate extinguisher class signage is correct and the extinguishers are at the appropriate height of less than 60 inches.</p> <p>4. The Facilities Manager will conduct ongoing monitoring by reviewing monthly and semi-annual inspection records of Engineering staff and Booth Fire and Safety.</p> <p>5. All corrective actions were completed by 08/22/12</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  08/03/2012
NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 468 BURNLEY RD. SCOTTSVILLE, KY 42164		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 064	Continued From page 21 suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.  Interview, on 08/01/12 between 1:00 PM and 4:30 PM with the Facilities Manager, revealed he was unaware of the signage requirement.  Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).  Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064			
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8	K 070	<i>K 070 The facility ensures portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F in accordance with NFPA 101 Life Safety Codes.</i>  1. On 07/31/12, the Facilities Manager identified that 22 residents on building 4 may be impacted. On 07/31/12, the Facilities Manager and Engineering staff immediately removed from the facility the three space heaters found in employee areas.	08/23/12	

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K 070	<p>Continued From page 22</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, 22 residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey. The facility failed to ensure 3 space heaters in employee areas did not exceed 212 degrees Fahrenheit.</p> <p>The findings include:</p> <p>Observation, on 07/31/12 between 1:15 PM and 4:30 PM with the Facilities Manager, revealed a portable space heater located in the Business Office Managers, Human Resources, and Assistant Director of Nursing offices.</p> <p>Interview, on 07/31/12 between 1:15 PM and 4:30 PM with the Facilities Manager, revealed he was not aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of</p>	K 070	<p>Continued from page 22</p> <p>2. On 07/31/12, the Facilities Manager and Engineering staff identified that no other residents were impacted. The facility was inspected on 07/31/12 by Engineering staff and no other space heaters were found.</p> <p>3. On 08/22/12, the Facilities Manager notified all staff that space heating devices cannot be brought into the facility without prior inspection and approval by the Facilities Manager. All Managers will inspect their respective areas monthly to ensure no space heating devices are brought into the facility and report their findings monthly to the Facilities Manager.</p> <p>4. All requests for space heating devices will be presented for approval by the Facilities Manager to the Safety Sub-Committee (Administrator, Facilities Vice President/ Corporate Security Officer, Facilities Manager, DON &amp; Clinical Educator) prior to being brought into the facility.</p> <p>5. All corrective actions were completed by 08/23/12</p>	

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K 070 K 072 SS=E	<p>Continued From page 23 such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, 77 residents, staff and visitors. The facility is certified for one-hundred ten (110) beds and the census was one-hundred seven (107) on the day of the survey. The facility failed to ensure linen carts and lifts were properly stored out of the corridor when not in use.</p> <p>The findings include:</p> <p>Observation, on 07/31/12 between 11:00 AM and 4:00 PM with the Facilities Manager, revealed lifts and linen carts stored in the corridor from 11:00 AM till 4:00 PM located in the north corridor in building 4 and north and south corridors of building 5.</p> <p>Interview, on 07/31/12 between 11:00 AM and 4:00 PM with the Facilities Manager, revealed the facility routinely stored the linen carts in the</p>	K 070 K 072	<p><b>K 072</b> It is the policy and ongoing facility practice to ensure that residents at Cal Turner Rehab and Specialty Care and their environments remain free of accidents and hazards and to maintain a means of egress for the event of fire or other emergency. No furnishings, decorations, or other objects will obstruct exits, access to, egress from, or visibility of exits.</p> <p>1. On 7/31/12, the Administrator, Director of Nursing and Facilities Manager identified that 77 residents on B Hall and C Hall may be impacted. On 07/31/12, all lifts, linen carts, and wheel chairs were placed into storage by nursing staff when not in use, to establish a means of egress for any event of fire or other emergency. This was reinforced daily by the Administrator, Facilities Manager, DON, Charge Nurse, and restorative nurse through 8/3/12.</p> <p>2. On 07/31/12, the Administrator and Facilities Manager identified that no other residents were impacted.</p> <p>3. Effective 08/06/12, the Administrator, Facilities Manager and DON will inspect corridors weekly when rounding to ensure linen carts or lifts are not stored in corridors. Any linen carts or lifts not in use and stored in corridors will be removed immediately. Starting 8/8/12, licensed staff of B Hall and C Hall will round to ensure all soiled and clean linen carts and lifts are placed in storage when not in use. Starting 08/22/12, the Charge Nurse will inspect corridors daily to ensure carts or lifts are not stored in hallways. On 08/22/12 all long term care staff were reminded by email that linen carts and lifts cannot be stored in corridors.</p>	08/23/12

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K 072	Continued From page 24 shower rooms. He was unaware the carts had been in the corridors for such a long period of time during the survey.  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	Continued from page 24 4. Monitoring began 8/6/12 for administrative weekly rounding of the facility to ensure linen carts and lifts were not stored in corridors. Individual education or performance counseling will be provided by the DON to any staff that fails to follow policy and procedural guidelines regarding storage of linen carts and lifts. The DON will be responsible for ongoing compliance. 5. <i>Corrective Actions were completed by 8/23/12.</i>	08/23/12	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated.  The findings include:  Observation, on 07/31/12 between 1:00 PM and 4:30 PM with the Facilities Manager, revealed several stuffed animals, wreaths, and fake floral arrangements throughout the facility with no flame retardant applied. Room numbers B21, B20, B22, and B24 are some examples of this	K 073	<i>K 073 The facility has no decorations brought into the facility without being properly fire treated.</i>  1. On 07/31/12, the Facilities Manager identified that all residents may be impacted. As of 08/02/12, Engineering staff inspected all resident rooms and treated all stuffed animals, wreaths, and fake floral arrangements with flame retardant. 2. On 07/31/12, the Facilities Manager identified that all residents may be impacted. 3. As of 08/02/12, residents and families were notified in person or by mail that all decorations must be inspected and treated with flame retardant by the Engineering staff prior to being allowed in the resident's rooms. Any new residents and their families will receive the same guidelines regarding bringing in flammable decorations.		

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER EXTENDED CARE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSDALE, KY 42164	
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K 073	Continued From page 25 deficiency  Interview, on 07/31/12 between 1:00 PM and 4:30 PM with the Facilities Manager, revealed he was aware decorations were required to be treated with a fire retardant spray and that any item brought into the facility was supposed to be checked in on arrival. Further interview determined the Facilities Manager was more aware of the wreaths needing treating instead of the stuffed animals and fake floral arrangements. The facility was made aware the decorations are not required to be removed, but if the decorations are going to be in the rooms they must be treated with a flame-retardant spray.  Reference: NFPA 101 (2000 Edition)  19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.  NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, 22 residents, staff and visitors. The facility is certified for one-hundred ten (110) beds and the census was one-hundred seven (107) on the day of the survey. The facility	K 073	Continued from page 25  4. As of 8/22/12, Engineering staff have been assigned ongoing monthly room inspections of each patient room to ensure all flammable decorations have been treated and labeled. The work order system, and facility "rounds" will be utilized to ensure the assignments are completed. The DON will be responsible for ongoing compliance. <b>5. All corrective actions have been completed by 8/23/12.</b>  K 130 The facility maintains hazardous areas in accordance with NFPA standards. On 07/31/12, the Facilities Manager identified 22 residents may be impacted on building 4. On 07/31/12, the Engineering staff removed the lint build-up in the room behind the dryers. On 08/22/12, Warren County Sheet Metal installed steel bollards in front of the gas main to ensure additional protection. 2. On 07/31/12, the Facilities Manager identified that there no other residents impacted. 3. Effective 08/22/12, the Engineering staff had modified the work order system to include a monthly preventive maintenance task and the staff will remove lint build-up from the room behind the dryers monthly. 4. Effective 08/22/12, the Facilities Manager will monitor the monthly completion of preventive maintenance documents to include removal of lint build-up in the room behind the dryers. <b>5. All corrective actions were completed by 08/23/12</b>	08/23/12
K 130 SS=D		K 130		

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K 130	<p>Continued From page 26</p> <p>failed to ensure the area behind the dryers was properly maintained to be free of lint buildup and the gas main was properly protected from equipment.</p> <p>The findings include:</p> <p>Observation, on 7/31/12 at 4:42 PM with the Facilities Manager, revealed a heavy build-up of lint, in the entire room that is behind the dryers.</p> <p>Interview, on 7/31/12 at 4:42 PM with the Facilities Manager, revealed he was not aware the lint build up was so excessive.</p> <p>Observation, on 08/01/12 at 4:30 PM with the Facilities Manager, revealed there was no protection against physical damage to the gas main located outside the back of the building at the truck unloading area. The gas main is located directly next to the drive area and is protected from the side but there was not protection to the front of the gas main.</p> <p>Interview, on 08/01/12 at 4:30 PM with the Facilities Manager, revealed he was not aware the gas main needed to have protection in front and the sides due to the location of the gas main.</p> <p>Reference: NFPA 101 (2000 Edition) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature</p>	K 130			

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K 130	Continued From page 27 shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 130			
K 144 SS=F	Reference: NFPA 101 (2000 Edition) Gas meters, regulators and piping must be protected against physical damage in an approved manner when exposed to equipment traffic. The barriers must be designed to the largest piece of equipment that would be typically parked or used in the immediate area. NFPA 54, National Fuel Gas Code NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds and the census was one-hundred seven (107) on the day of the survey. The facility failed to ensure the generator enclosure did not have	K 144	<b>K 144</b> <i>The facility ensures emergency generators are maintained in accordance with NFPA standards and does not have any storage inside.</i>  1. On 08/01/12, the Facilities Manager identified that all residents may be impacted. On 08/01/12, Engineering staff removed all items found stored inside the generator enclosure. This included battery saver, oil, diesel improver, and milk crate. 2. On 08/01/12, the Facilities Manager identified that all residents may be impacted. 3. On 08/01/12, all Engineering staff were educated on generator maintenance in accordance with NFPA standards to include not storing anything in the generator cabinet. Starting 08/22/12, all generator inspections will include checking to ensure no items are stored in the generator cabinet. This item was added to the generator inspection log. 4. Starting 08/22/12, all generator inspection logs by Engineering staff will be reviewed monthly by the Facilities Manager. The Facility Manager will inspect the generator during routine facility "rounds" to ensure no items are stored in the generator. 5. <b>All corrective actions were completed by 08/23/12</b>	08/23/12	

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K 144	Continued From page 28 any storage inside.  The findings include:  Observation, on 08/01/12 at 4:45 PM with the Facilities Manager, revealed the facility was equipped with an emergency generator. The enclosure for the generator had battery saver, oil, and diesel improver stored in a milk crate inside the enclosure.  Interview, on 08/01/12 at 4:45 PM with the Facilities Manager, revealed he was not aware the flammable items were being stored inside the generator enclosure.  Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.	K 144			