

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

PRINTED: 11/28/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185236 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 11/09/2012 |
| NAME OF PROVIDER OR SUPPLIER OWENSBORO PLACE CARE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | INITIAL COMMENTS | F 000 | | | |
| F 282 SS=G | <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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: 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 ensure one resident (#1), in the selected sample of fifteen residents, was provided care in accordance with the plan of care. The resident was totally dependant on staff for mobility and was care planned for transfers with the assistance of two staff. On 09/04/12, a Hospice Certified Nurse Aide (CNA) transferred Resident #1 from a geri-chair to his/her bed without additional assistance as required per the plan of care. The Hospice CNA immediately noticed a discoloration to the resident's right foot and notified the nurse. An X-ray was obtained and revealed the resident sustained a fracture to the tibia and fibula near the ankle. The facility determined the fracture occurred when the</p> | F 282 | F 282G | 12/8/12 | |
| | | | <p>1. Resident #1 was transferred to an Orthopedic physician for evaluation and treatment on 9-6-12. The Hospice CNA assigned to Resident #1 was re-educated on 9-11-12 by the facility Administrator and Director of Nursing on following the residents' facility care plan and asking for assistance with all resident transfers. The bed for Resident #1 was placed in low position by a certified nursing assistant on 11-6-12. A care plan meeting was held on 11-6-12 with the facility Interdisciplinary Team and the Hospice Nurse to determine that facility and Hospice care plans mirrored one another including the amount of assistance needed with transfers and bed height.</p> <p>2. An audit of current residents and resident care plans was completed by the Unit Managers on 12/4/12 to determine that care plan interventions are implemented. An audit of Hospice and facility care plans, for current residents receiving hospice services, was completed by the Director of Nursing on 11/12/12 to determine that both facility and Hospice care plans mirror one another related to resident care needs including the amount of assistance needed with transfers and bed height. Any issues identified were corrected at that time.</p> | | |

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

Wendell Smith

TITLE

Administrator

(X6) DATE

1/18/13

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

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| F 282 | <p>Continued From page 1</p> <p>Hospice CNA transferred the resident without assistance. (Refer to F309)</p> <p>Additionally, review of Resident #1's care plan, Risk for Falls, revealed an intervention dated 08/06/12 to keep the resident's bed in a low position. However, during the abbreviated survey, Resident #1 was observed in a bed which was not in low position in accordance with the resident's care plan.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, Interdisciplinary Care Plan, dated 01/2008, revealed "The Interdisciplinary Team (IDT) develop care plans within 24 hours of admission addressing the resident's most acute problems. The care plan is comprehensive for each resident including measurable objectives and timetable to meet resident's medical, nursing, and mental and psychosocial needs."</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/05 with diagnoses to include Osteoporosis, End Stage Alzheimer's Disease, Dysphagia, Ischemic Heart Disease, Osteoarthritis, Malaise and Fatigue. Further review revealed Resident #1 was placed on the Hospice case load on 06/29/11.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment, dated 03/20/12, revealed the facility assessed the resident to be unable to complete the interview in order to determine his/her cognitive status. The facility assessed the resident was totally dependent, requiring two staff for bed mobility and two staff for transfers. A</p> | F 282 | <p>3. The Hospice Clinical Manager was re-educated on 9-5-12 by the Director of Nursing regarding following the residents' facility plan of care and that hospice care plans should mirror the facility care plan including the amount of assistance needed for transfers and bed height. The facility nursing staff was re-educated by the Staff Development Coordinator on 11/6/12 and 11/30/12 to follow resident care plans which included the amount of assistance needed for transfers, bed height and providing hospice staff assistance with transfers and a copy of the resident care card at the beginning of each resident visit by Hospice staff. Licensed nurses will be responsible for setting and monitoring the settings for LAL mattresses.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will complete an audit of 10 residents, including at least 2 residents receiving hospice services, 2 times per week x4 weeks and then monthly to determine that care plans are implemented as indicated. The interdisciplinary care team will ensure that the Hospice and Facility care plans mirror each other related to assistance needed for ADLs. Any concerns identified will be corrected immediately. A summary of findings will be submitted by the Director of Nursing to the Performance Improvement Committee monthly x6 months for further review and recommendation.</p> | |

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| F 282 | <p>Continued From page 2</p> <p>review of the comprehensive care plan, Self Care Deficit, revealed an intervention to include "Requires two total staff for bed mobility, transfers, dressing, toileting, bathing and grooming."</p> <p>A review of the Hospice care plan, dated 04/23/12 for Activity/Mobility, revealed "Managed with current Plan of Care interventions/monitoring." Further review of the Hospice care plan did not specify the amount of assistance required for transfers.</p> <p>Review of an annual MDS assessment, dated 06/18/12, revealed the facility assessed the resident's cognitive status as modified independence, having some difficulty in new situations only. He/she was totally dependent, requiring two staff for bed mobility and two staff for transfers.</p> <p>Review of the Nurse Aide Care Plan, dated 09/2012, revealed bed mobility and transfers were to be two person assistance.</p> <p>Review of a Change of Condition document, dated 09/04/12 at 2:10 PM, revealed notes that described a bruise on the top of the resident's right foot measuring 6.6 centimeters (cm) long by 4.7 cm wide and bluish purple in color. The right foot was turned inward at the ankle and the resident complained about pain when lifted. The physician was notified and an order was received to obtain an X-ray.</p> <p>Review of the facility's investigation revealed, on 09/04/12, the Hospice CNA notified the nurse about the resident's foot being discolored, and the</p> | F 282 | | |

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| F 282 | <p>Continued From page 3</p> <p>facility determined the Hospice CNA transferred the resident without assistance and was unaware that Resident #1 was a two-assist transfer. The facility determined the injury was the result of the inappropriate transfer.</p> <p>Interview with the Hospice CNA, on 11/08/12 at 11:25 AM, revealed she provided care for Resident #1 two times a week such as bathing, appropriate activities, and feeding. The Hospice CNA revealed she did not get a report related to the residents she cared for each time she came to the facility; however, she did talk to the facility CNAs from time to time. The Hospice CNA stated she never looked at the facility Nurse Aide care plan and never documented on any facility document. She always transferred Resident #1 alone except when using a shower chair. The CNA had a Call Track (palm held information device) that she referred to for information about the residents she cared for. She stated the information in the Call Track did not specify Resident #1 to be a two person assist with transfers. She stated she observed facility CNAs transferring Resident #1 alone on multiple occasions and the facility nurse did oversee the care she provided. Additionally, the Hospice CNA stated, that on 09/04/12, Resident #1 was up in a geri chair when she arrived and she transferred him/her to the bed without assistance, as usual. She was going to provide a bed bath to Resident #1 and when she removed the resident's sock from the right foot, she noticed it "did not look right and felt funny." The nurse on duty was notified. The Hospice CNA filled out an incident report at the Hospice office, and the facility Director of Nursing (DON) spoke to her about the resident being a two person assist the next time</p> |
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| F 282 | <p>Continued From page 4 she came to the facility.</p> <p>Further review of the comprehensive care plan, Risk for falls, revealed an intervention, dated 08/06/12, "Keep the bed in low position."</p> <p>An observation, on 11/06/12 at 3:10 PM, revealed Resident #1's bed was at regular middle height. CNA #5 verified the bed position was at the middle setting, and then lowered the bed to the low position; however, the CNA revealed she was unaware Resident #1's bed was suppose to be in the low position.</p> <p>An interview with the Clinical Case Manager, MDS Coordinator, on 11/09/12 at 11:00 AM, revealed the facility charge nurses were responsible to ensure care was provided as per the resident's care plan. She stated "When they (referring to Hospice staff) were in the building, we have to watch and ensure they know what to do." She stated Hospice nurses attended the facility care plan meetings and signed off on the signature log about understanding the plan of care.</p> <p>An interview with Hospice Director of Quality Compliance and Education and Clinical Team Coordinator, on 11/09/12 at 11:15 AM, revealed the Hospice and facility care plans should mirror each other. The Hospice Director of Quality Compliance stated Resident #1's Hospice care plan did not specify the resident required two person assist transfers nor about the resident's low bed, but should have. The facility was responsible to ensure care was provided per the care plan and stated "hopefully they are observing."</p> | F 282 | | |

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| F 282 | Continued From page 5 An interview with the DON, on 11/06/12 at 6:45 PM, revealed Resident #1 was in a low bed. Further interview with the DON, on 11/07/12 at 8:30 AM, revealed when a resident was accepted for the Hospice program, that Hospice provided their own care plans. However, she revealed that it was she and the facility staff who were responsible to ensure care plans were followed by the Hospice CNAs. | F 282 | | | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure and investigation, it was determined the facility failed to ensure it provided the necessary care and services to attain or maintain the highest practicable physical, mental well being in accordance with the comprehensive assessment and Plan of Care for one resident (#1), in the selected sample of fifteen residents. The facility assessed Resident #1 to require two person assistance with transfers and developed a plan of care detailing the assistance required. The facility failed to ensure a Hospice Certified Nurse Aide (CNA) was knowledgeable and | F 309 | F 309G 1. Resident #1 was transferred to an Orthopedic physician for evaluation and treatment on 9-6-12. The Hospice CNA assigned to Resident #1 was re-educated on 9-11-12 by the facility Administrator and Director of Nursing on following the residents' facility care plan and asking for assistance with all resident transfers. The bed for Resident #1 was placed in low position by a certified nursing assistant on 11-6-12. A care plan meeting was held on 11-6-12 with the facility Interdisciplinary Team and the Hospice Nurse to determine that facility and Hospice care plans mirrored one another including the amount of assistance needed with transfers and bed height. 2. An audit of current residents and resident care plans was completed by the Unit Managers on 12/4/12 to determine that care plan interventions are implemented. An audit of Hospice and facility care plans, for current residents receiving hospice services, was completed by the Director of Nursing on 11/12/12 to determine that both facility and Hospice care plans mirror one another related to resident care needs including the amount of assistance needed with transfers and bed height. Any issues identified were corrected at that time. | 12/8/12 | |

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| F 309 | <p>Continued From page 6</p> <p>followed the care plan related to two person assist with transfers. On 09/04/12, Resident #1, who was a Hospice resident, was transferred by a Hospice CNA without the recommended second person assist. The resident sustained a fractured lower right leg. The facility determined the cause of the injury was due to one person assist provided by the Hospice CNA. (Refer to F282)</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, Interdisciplinary Care Plan, dated 01/2008, revealed "The Interdisciplinary Team (IDT) develop care plans within 24 hours of admission addressing the resident's most acute problems. The care plan is comprehensive for each resident including measurable objectives and timetable to meet resident's medical, nursing, and mental and psychosocial needs."</p> <p>A record review revealed the facility admitted Resident #1 on 07/01/05 with diagnoses to include Osteoporosis, End Stage Alzheimer's Disease, Dysphagia, Ischemic Heart Disease, Osteoarthritis, Malaise and Fatigue. Resident #1 was placed on Hospice case load on 06/29/11.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment, dated 03/20/12, revealed the facility assessed the resident to be unable to complete the interview in order to determine his/her cognitive status. He/she was totally dependent, requiring two staff for bed mobility and two staff for transfers. A review of the comprehensive care plan, Self Care Deficit, revealed an intervention to include "Requires two total staff for bed mobility,</p> | F 309 | <p>3. The Hospice Clinical Manager was re-educated on 9-5-12 by the Director of Nursing regarding following the residents' facility plan of care and that hospice care plans should mirror the facility care plan including the amount of assistance needed for transfers and bed height. The facility nursing staff was re-educated by the Staff Development Coordinator on 11/6/12 and 11/30/12 to follow resident care plans which included the amount of assistance needed for transfers, bed height and providing hospice staff assistance with transfers and a copy of the resident care card at the beginning of each resident visit by Hospice staff. Licensed nurses will be responsible for setting and monitoring the settings for LAL mattresses.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will complete an audit of 10 residents, including at least 2 residents receiving hospice services, 2 times per week x4 weeks and then monthly to determine that care plans are implemented as indicated. The interdisciplinary care team will ensure that the Hospice and Facility care plans mirror each other related to assistance needed for ADLs. Any concerns identified will be corrected immediately. A summary of findings will be submitted by the Director of Nursing to the Performance Improvement Committee monthly x6 months for further review and recommendation.</p> | | |

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| F 309 | <p>Continued From page 7 transfers, dressing, toileting, bathing and grooming."</p> <p>A review of the Hospice care plan, dated 04/23/12 for Activity/Mobility, revealed "Managed with current Plan of Care interventions/monitoring." Further review of the Hospice care plan did not specify the amount of assistance required for transfers.</p> <p>Review of an annual MDS assessment, dated 06/18/12, revealed the facility assessed the resident's cognitive status as modified independence, having some difficulty in new situations only. He/she was totally dependent, requiring two staff for bed mobility and two staff for transfers.</p> <p>A review of the Nurse Aide Care Plan, dated 09/20/12, revealed bed mobility and transfers were to be two person assistance.</p> <p>Review of a Change of Condition Document, dated 09/04/12 at 2:10 PM, revealed notes that described a bruise on the top of the resident's right foot measuring 6.6 centimeters (cm) long by 4.7 cm wide and bluish purple in color. The right foot was turned inward at the ankle and the resident complained about pain when lifted. The physician was notified and an order was received to obtain an X-ray.</p> <p>Review of a radiology report, dated 09/04/12, revealed "Conclusion: acute or subacute fractures of the tibia and fibula with valgus angulation." The physician was notified regarding the findings. An order was received to wear an Aircast on the right ankle at all times, and may</p> | F 309 | | | |

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| F 309 | <p>Continued From page 8 remove daily for skin care.</p> <p>Review of the facility's investigation revealed, on 09/04/12, the Hospice CNA notified the nurse about the resident's foot being discolored, and the facility determined the Hospice CNA transferred the resident without assistance and was unaware that Resident #1 was a two-assist transfer. The facility determined the injury was the result of an accident and took steps to work with Hospice to prevent another such accident in the future.</p> <p>An interview with the Hospice CNA, on 11/08/12 at 11:25 AM, revealed she provided care for Resident #1 for a long time. She provided care to the resident two times a week such as bathing, appropriate activities, and feeding. The Hospice CNA revealed she did not get a report related to the residents she cared for each time she came to the facility; however, she did talk to the facility CNAs from time to time. The Hospice CNA stated she never looked at the facility Nurse Aide care plan and never documented on any facility document. She always transferred Resident #1 alone except when using a shower chair. The CNA had a Call Track (palm held information device) that she referred to for information about the residents she cared for. She stated the information in the Call Track did not specify Resident #1 to be a two person assist with transfers. She stated she observed facility CNAs transferring Resident #1 alone on multiple occasions and the facility nurse did oversee the care she provided. Additionally, the Hospice CNA stated, that on 09/04/12, Resident #1 was up in a geri chair when she arrived and she transferred him/her to the bed without assistance, as usual. She was going to provide a bed bath to Resident</p> | F 309 | | | |

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| F 309 | <p>Continued From page 9</p> <p>#1 and when she removed the resident's sock from the right foot, she noticed it "did not look right and felt funny." The nurse on duty was notified. The Hospice CNA filled out an incident report at the Hospice office, and the facility Director of Nursing (DON) spoke to her about the resident being a two person assist the next time she came to the facility.</p> <p>An interview with the Clinical Case Manager, MDS Coordinator, on 11/09/12 at 11:00 AM, revealed the facility charge nurses were responsible to ensure care was provided as per the resident's care plan. She stated "When they (referring to Hospice staff) were in the building, we have to watch and ensure they know what to do." She stated Hospice nurses attended the facility care plan meetings and signed off on the signature log about understanding the plan of care.</p> <p>An interview with Hospice Director of Quality Compliance and Education and Clinical Team Coordinator, on 11/09/12 at 11:15 AM, revealed Hospice nurses attended resident care plan meetings and CNAs do not attend those meetings. Hospice received a copy of the facility care plans and the facility had a copy of Hospice care plans. Hospice and facility care plans should mirror each other. The Hospice Director of Quality Compliance stated Resident #1's Hospice care plan did not specify the resident required two person assist transfers, but they should have. The Hospice nurses conducted supervisory visits every fourteen days to ensure care was being provided appropriately; however, they only watched the CNAs provide care once a year. The facility was responsible to ensure care</p> | F 309 | | |

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| F 309 | Continued From page 10 was provided per the care plan and stated "hopefully they are observing." An interview with the DON, on 11/07/12 at 8:30 AM, revealed when a resident was accepted for the Hospice program, that Hospice provided their own care plans. She stated the Hospice CNAs communicated with the nursing staff, but did not know if the Hospice CNA had a copy of the resident's facility care plan. The DON stated she did not meet with the Hospice CNA because Hospice had directed the care they provided; however, she revealed that it was she and the facility staff who were responsible to ensure care plans were followed by the Hospice CNAs. | F 309 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's investigation, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as is possible for two residents (#1 and #7), in the selected sample of fifteen residents, related to the failure to provide assessments for the safe use of specialty air | F 323 | F 323D 1. A Restrictive Device Assessment was completed for Resident #1 on 11/6/12 and for Resident #7 on 11/10/12 by a licensed nurse to consider resident safety with use. The air mattress setting for Resident #1 was adjusted according to manufacturer guidelines by the Director of Nursing on 11/8/12. The bed for Resident #1 was placed in low position on 11-6-12 by a certified nursing assistant. A copy of the manufacturer guidelines for the specialty mattress was obtained by the Director of Nursing on 11/8/12 for the facility staff to reference. 2. An audit of all current residents and resident rooms was completed to determine that if a specialty mattress is being used then a Restrictive Device assessment was completed to consider safety with the use of the specialty mattress, the settings of the specialty mattress were as recommended in the manufacturer guidelines, and that other measures to keep the resident's environment as free of accident hazards as is possible, including beds being placed in the recommended position on 11/9/12 by Director of Nursing, Assistant Director of Nursing and Unit Managers. Any concerns identified were corrected when identified. An audit of other resident care equipment was completed by the Director of Nursing and the Joernes technician on 11/7/12 to determine that manufacturer guidelines are in place and a copy is available for facility staff to reference. No other concerns were identified. | 12/8/12 |

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| F 323 | Continued From page 11 mattresses. Resident #1 sustained two falls from a specially air mattress and was placed back on the air mattress without an assessment for the safe use of it. Resident #1 was observed on the specially air mattress, which was not on the correct pressure setting. In addition, Resident #1's bed was not in a low position in accordance with the resident's care plan. Resident #7 sustained a fall from a specially air mattress and was placed back on the air mattress without an assessment for the safe use of it. The facility failed to ensure all staff were instructed on how to determine and maintain the appropriate settings of the specially air mattresses or what to do in case of a cardiac event. Additionally, the facility failed to ensure manufacturer instructions and guidelines for using the specially mattresses were available for the staff. Findings include: The facility provided no evidence of a specific policy/procedure for the use of specially air mattresses and followed Lippincott and Mosby as the standard of practice. Review of the Support Surfaces and Special Beds section (pg. 308) included "Some types of support surfaces require that the manufacturer's representative set up and maintain the support system." 1. A record review revealed the facility admitted Resident #1 on 07/01/05 with diagnoses to include Osteoporosis, End Stage Alzheimer's Disease, Dysphagia, Ischemic Heart Disease, Osteoarthritis, Malaise and Fatigue. Further review revealed Resident #1 was placed on the Hospice case load on 06/29/11, and a specially air mattress was obtained for the resident on | F 323 | 3. Licensed nurses and certified nursing assistants were re-educated to the use of specially mattresses, following manufacturer guidelines, and to ensure that the resident's environment remains as free of accident hazards as possible including placing beds in low position as indicated on 11/6/12, 11/7/12, and 11/12/12 by the Staff Development Coordinator. Licensed nurses will be responsible for setting and monitoring the settings for LAL mattresses. 4. The Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will complete an audit of all current residents using an air mattress to determine that the setting is as indicated and that the resident safety with use of the mattress has been assessed, and at least 20 other residents to determine that their environment is free of hazards including beds placed at the recommended height weekly x4 weeks, monthly x2 months and then quarterly x1. The interdisciplinary care team will ensure that the Hospice and Facility care plans mirror each other related to assistance needed for ADLs. Any concerns identified will be corrected when identified. A summary of findings will be submitted to the Performance Improvement Committee monthly x6 months for review and further recommendation. | | |

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| F 323 | Continued From page 12 10/03/11. Review of the resident's record revealed there was no evidence the facility assessed Resident #1 for the safe use of the specially mattress. Review of two Change of Condition documents, dated 08/08/12 at 9:30 AM, revealed "Resident and sheet slipped off bed during transfer" and "Neuro check within normal limits." Additional documentation included "Discoloration noted to forehead after fall." Review of an event report, dated 08/06/12, revealed Resident #1 slipped off the bed along with the sheet as CNA #5 was turning the resident to provide care. The report detailed ensuring the sheets were in proper placement and this intervention was placed on the resident's Risk for Falls care plan. Review of a quarterly MDS assessment, dated 09/18/12, revealed the facility assessed the resident to be severely cognitively impaired. Further review of the resident's MDS revealed "bed mobility/transfer" activity did not occur, which meant the activity (or any part of the ADL) was not performed by the resident or staff at all over the entire 7 day look back period. Review of the care plan, Risk for falls, reviewed 09/20/12, revealed an intervention, dated 08/06/12, "Keep the bed in low position and ensure sheets are properly placed prior to care given while in bed." Review of a Change of Condition document, dated 10/21/12 at 8:20 PM, revealed Resident #1 was found by staff on the floor next to the bed and he/she complained about left arm pain and exhibited "guarding" when moved. An x-ray was | F 323 | | | |

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| F 323 | <p>Continued From page 13</p> <p>ordered and obtained. No fracture was identified. Review of an Event Report, dated 10/21/12, revealed Resident #1 was "Found lying on the floor with his/her legs and feet still on the bed. Redness was noted to the left shoulder. Guarded arm when doing ROM (range of motion). Stated yes when asked if his/her arm hurt."</p> <p>An observation, on 11/06/12 at 3:10 PM, revealed Resident #1 was lying on a specialty air mattress, with the control for the air mattress set for a resident weighing 150 pounds. However, review of a quarterly nursing assessment, dated 09/16/12, revealed Resident #1's current weight was 84.1 pounds. The bed was at regular middle height. Certified Nurse Aide (CNA) # 5 verified the bed position was at the middle setting, and then lowered the bed to the low position. Per interview, the CNA did not have any training on specialty air mattresses and only the nurses were responsible for the bed settings.</p> <p>An interview with the Director of Nursing (DON), on 11/06/12 at 6:45 PM, revealed Resident #1 was in a low bed. She stated the specialty air mattress was suppose to be set according to the resident's weight and verified the bed was actually set for a resident who weighed 150 pounds.</p> <p>2. A record review revealed the facility admitted Resident #7 on 08/16/11 with diagnoses to include Multiple Sclerosis, Above the Knee Amputation, Restless Leg Syndrome, Contracture of Joint, Multiple Sites, and Personal History of Fall.</p> <p>Record review revealed a specialty air mattress</p> | F 323 | | |

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| F 323 | <p>Continued From page 14</p> <p>was utilized due to skin issues. Review of an Incident Report and Change of Condition Document, dated 04/08/12 at 7:00 PM, revealed the resident fell from the bed when reaching for something. No injury was identified. A bed alarm was added to alert the staff. There was no evidence the facility assessed Resident #7 for the safe use of the specially air mattress. The facility's investigation regarding the fall did not address that the resident fell from a specially mattress nor did it address that the mattress could be a contributing factor for the fall. Resident #7 was placed back on the specially air mattress.</p> <p>Review of a quarterly MDS assessment, dated 10/12/12, revealed the facility assessed the resident to be cognitively impaired and was totally dependant on staff for bed mobility and transfers.</p> <p>An observation, on 11/07/12 at 5:30 PM, revealed Resident #7 was lying on a specialty air mattress. The control box for the air mattress was sitting on the floor unsecured. An interview with the resident was attempted; however, the resident was determined to be cognitively impaired and unable to provide reliable information.</p> <p>An interview with a Delivery/Support Technician, on 11/08/12 at 3:05 PM, revealed the dial control for Resident #7's bed was to be set according to his/her weight. He stated he gave instructions to a Licensed Practical Nurse (LPN) who was present upon delivery, but no other staff inservice was completed at the time. He stated an inservice could be scheduled if the facility desired.</p> | F 323 | | | |

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| F 323 | <p>Continued From page 15</p> <p>An interview with the Staff Development Coordinator, on 11/08/12 at 9:30 AM, revealed she had not provided any training to any staff related to specialty air mattresses including assessments for the safe use of, determination of control settings or monitoring, or procedures for managing cardiac emergencies of residents that would be on a specialty air mattress.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 11/09/12 at 11:30 AM, revealed assessments were completed to determine if a specialty air mattress was appropriate and potentially a restraint for a resident; however, no assessment was completed for the safe use of a specialty air mattress. Additionally, the ADON stated there was no system in place to monitor specialty air mattresses for the appropriate and safe setting.</p> <p>An interview with the DON, on 11/09/12 at 11:55 AM, revealed the facility did not identify the air mattresses as a potential cause of the falls of Resident #1 and Resident #7, and was not considered during investigation of the falls. The residents were placed back on the air mattress after the falls. The DON stated there was no system to assess residents for the safe use of a specialty air mattress. Additionally, there was no system to ensure nursing staff routinely monitored the specialty air mattresses for proper and safe settings, and that manufacturer's guidelines were not available in the facility as a resource for staff. The DON stated training was provided to the nursing staff who was present on delivery by the person delivering the specialty mattresses; however, she could not verify any staff was trained related to the specialty air</p> | F 323 | | | |

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| F 323 | Continued From page 16 mattresses. An interview with the Administrator, on 11/09/12 at 12:30 PM, revealed he was not aware the facility did not assess for the safe use of specialty air mattresses prior to residents being placed on them. | F 323 | | |
| F 454 SS=E | 483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the manufacturer's guidelines, it was determined the facility failed to be maintained to protect the health and safety of residents, personnel and the public. Observation, on 11/06/12, revealed resident care equipment plugged into a power strip instead of an approved outlet. Additionally, a specialty air mattress utilized by a resident was observed with the power cord patched with electrical tape in two areas. Findings include: Review of the manufacturers's guidelines for specialty air mattresses provided from the manufacturer, after surveyor request (was not available at facility on 11/06/12), revealed under the WARNING section "If this product has a damaged power cord or plug, is not working properly, has been dropped or damaged, or has been dropped into water, do not operate it. For examination and repair, return the product to | F 454 | F454 1. The air mattress in 403A (D wing) was plugged into a grounded outlet and the power strip removed by the Director of Nursing on 11/8/12. The air mattress in room 523B (E wing) was replaced on 11/9/12 by Maintenance. The nebulizer machine, BiPap machine, oxygen concentrator, and a battery charger in room 304B (C Wing) were plugged into the proper wall outlet and the power strip removed by Maintenance on 11/9/12. 2. An audit of the facility electric beds and all air mattresses was completed by the Maintenance Department on 11/26/12 to determine any health and safety concerns including the use of power strips and that medical equipment is plugged into the proper outlets and that the air mattress power cords were intact. Any concerns identified were corrected at that time. | 12/8/12 |

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| F 454 | <p>Continued From page 17</p> <p>manufacturer." Additionally, the guidelines revealed "Plug this product only into a properly grounded outlet. Refer to Grounding Instructions." The Grounding instructions revealed "WARNING: use properly grounded, three-prong, 120V AC outlet for this product. Failure to use a grounded outlet could result in personal injury or damage to equipment or house wiring, including risk of fire. A qualified electrician should be contacted to correct the wiring and ensure a properly grounded outlet."</p> <p>An observation in Room 403A (D Wing), on 11/06/12 at 3:10 PM, revealed a resident was laying on a specialty air mattress. The mattress was plugged into a power strip instead of the wall outlet.</p> <p>Further observation in Room 523B (E Wing) revealed a resident was laying on a specialty air mattress. The electrical cord of the air mattress was laying on the floor under the resident's bed and two areas of the cord were patched with black electrical tape.</p> <p>Additional observation in Room 304B (C Wing) revealed a nebulizer machine, a BiPap machine, an oxygen concentrator, and a battery charger were plugged into a power strip instead of the proper wall outlet.</p> <p>An interview with the Maintenance Director, on 11/07/12 at 9:30 AM, revealed he often repaired specialty air mattresses. He stated the mattresses developed leaks at times and he "fixed them." He stated the electrical cords sometimes got holes in them from the beds being rolled over the cords. He stated a quick fix was to</p> | F 454 | <p>3. The Maintenance Director and Director of Nursing was re-educated by the Administrator on maintaining the facility to protect the health and safety of everyone including the use of power strips in the center and following manufacturer guidelines and keeping a copy of manufacturer guidelines for facility staff to reference on 12/7/12. Facility staff were re-educated to maintaining facility safety including the use of power strips and following manufacturer guidelines with medical equipment such as air mattresses by Staff Development Coordinator on 12/6/12. Duplex electrical outlets will be replaced with quad-outlets, making more "hard-wired" outlets available for medical equipment. The order for the quad-outlets was placed on 11/30/12, but part of the order is on "back-order" and will be installed as soon as possible after they arrive. The Maintenance Department will perform inspections of each room monthly to determine that unsafe conditions are not present affecting residents, employees, or visitors, in addition to other needed repairs. The Maintenance Department will follow manufacturers' guidelines.</p> <p>4. The Administrator and/or the Maintenance Director will complete an audit of the facility monthly to determine that the facility is maintained to protect the health and safety of everyone, including the use of power cords and the integrity of air mattress power cords. Any issues identified will be corrected at the time identified. A summary of findings will be presented to the Performance Improvement Committee monthly x6 months for review and further recommendations.</p> | |

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| F 454 | Continued From page 18 tape the damaged areas until he could get the cords replaced. The Maintenance Director stated "I have a spool of cord and I make a new cord." He did not always call the manufacturer because he "could do what they do" and he made the decision to fix it himself or call someone. The Maintenance Director stated he was not a licensed electrician and he was unsure if there was a policy related to maintenance of resident equipment. Additionally, the Maintenance Director stated no resident care equipment should ever be plugged into a power strip. He stated he tried to keep power strips out of the facility, but could not verify there was a system to ensure they were not used. An interview with the Director of Nursing (DON), on 11/06/12, revealed she was unaware that resident care equipment should not be plugged into power strips. | F 454 | F456 1. The control boxes for the air mattresses used in rooms 108A (A wing) and 312B (C wing) were secured to the foot of the bed by the Maintenance Director on 11/9/12. | 12/8/12 |
| F 456 SS=E | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the manufacturer's guidelines, it was determined the facility failed to ensure all mechanical and resident care equipment was maintained in a safe operating condition. Observations revealed specialty air mattress control boxes were unsecured on the floor. | F 456 | 2. An audit of all essential equipment was completed by the Maintenance Department on 11/26/12 to determine that essential equipment is maintained appropriately, including that air mattress control boxes are secured to the foot of resident beds. Any issues identified were corrected at the time identified. 3. The Maintenance Director was re-educated by the Administrator on 12/7/12 to maintain all essential equipment in safe operating condition including that air mattress control boxes are secured to the foot of resident beds. Nursing, housekeeping, therapy, Social Services, and Activities were re-educated to maintaining essential equipment including securing air mattress control boxes to the foot of the bed and communicating any concerns identified to Maintenance staff by the Staff Development Coordinator on 12/7/12. | |

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| NAME OF PROVIDER OR SUPPLIER OWENSBORO PLACE CARE AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1206 LEITCHFIELD RD. OWENSBORO, KY 42303 |
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| (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 |
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| F 456 | <p>Continued From page 19</p> <p>Findings include:</p> <p>Review of the manufacturer's guidelines for specialty air mattresses provided from the manufacturer, after surveyor request (was not available at facility on 11/06/12), revealed "Do not place the control unit on the floor. Position the power cord to keep personnel from tripping over it," and "Hang the control unit on the foot of the bed facing away from the bed."</p> <p>On 11/06/12 starting at 3:10 PM, observations of resident care equipment was conducted throughout the facility. In Room 108A (A wing), a resident was laying on a specialty air mattress. The control box for the air mattress was not attached to the resident's bed, and was sitting unsecured on the floor by the bed.</p> <p>Observation in Room 312B (C Wing) revealed a resident was laying on an air mattress and the control box was sitting unsecured on the floor.</p> <p>An interview with the Maintenance Director, on 11/09/12, revealed the control boxes should not be unsecured on the floor and he was instructed to repair the boxes so they could be secured on the bed as recommended.</p> | F 456 | <p>4. The Administrator and/or the Maintenance Director will complete an audit of the facilities essential equipment including air mattress control boxes are secured to the footboard of the beds monthly. Any issues identified will be corrected at the time identified. A summary of findings will be presented to the Performance Improvement Committee monthly x6 months for review and further recommendation.</p> | |
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