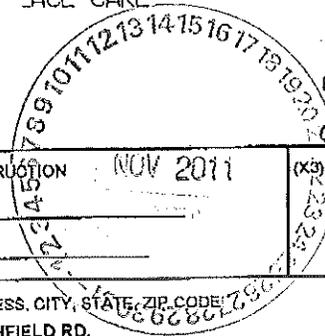


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  An annual recertification survey was conducted, on 10/18/11 through 10/21/11, and a Life Safety Code survey was conducted on 10/20/11, to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "F".  Abbreviated surveys, KY#18363, KY #16365, KY#16366, KY #16469, KY#16685, KY#17160, KY#17165, KY#16218, KY#16367 and KY#16368 were conducted in conjunction with the annual survey. KY#16365, KY#17165, KY#16363 and KY#16368 were Substantiated, KY#16366, KY#16685, KY#16218, KY#16367, KY#16469, and KY#17160 were unsubstantiated.	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Owensboro Place Care &amp; Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>1. The physician for resident #26 was notified of the resident's change in condition on 10/19/2011 by the charge nurse. Resident #24 no longer resides in the facility.</p> <p>2. The 24 hour report, medication administration records and skin assessment forms were reviewed by the Director of Nursing</p>		
F 157 SS=D	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 §483.12(a).	F 157			

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

TITLE

(X6) DATE

*Wendell A. Smith*

*Administrator*

*11/14/11*

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

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F 157	<p>Continued From page 1</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 observations, record reviews and interviews, it was determined the facility failed to notify the physician when a change in the resident's condition occurred, which had the potential for physician intervention and/or alteration in treatment for one resident, (#24), in the selected sample of 24 and one resident (#28), not in the selected sample.</p> <p>Resident #24 developed a change in skin condition. The facility failed to notify and consult with the physician. Resident # 26's physician ordered medication was unavailable for administration. The facility failed to notify and consult with the resident's physician.</p> <p>The findings include:</p> <p>A review of the facility's, "Skin Care &amp; Pressure Ulcer Management Program", dated January 2008, revealed the facility assessed risk factors and developed a plan of care to address resident</p>	F 157	<p>Services, the Assistant Director of Nursing Services, and Unit Managers to determine if any resident had a change in condition and that the physician or responsible party had been notified on 10/21/2011. No other residents were affected.</p> <p>3. The licensed nursing staff were re-educated by the Staff Development Coordinator on 11/7/2011 regarding notification of change in condition and ordered medication not available to the physician. The Certified Medication Technicians were re-educated by the Staff Development Coordinator on 11/7/2011 on notifying the charge nurse of any medication not available.</p>	

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F 157	Continued From page 2 skin concerns. According to the policy, a licensed nurse was to perform a head to toe skin check of the resident and document the findings. The policy contained forms to be utilized by the licensed nurse; a "Pressure Ulcer Documentation Form" and a "Non-Pressure Wound and Skin Condition Documentation Form". According to the policy, if an area was identified during care, the nursing assistant informed the licensed nurse who validated the observation by examining the resident. If the nurse determined the identified area was a new skin issue, the nurse completed an investigation process. The investigation process instructed the nurse to consider any new skin issue to be an "Incident" and to complete an investigation to determine root cause. The nurse was also instructed to inform the physician and responsible party.  1. A review of the medical record, revealed Resident # 24 was admitted to the facility, on 01/19/10, with diagnoses which included End Stage Renal Disease with Dialysis and Peripheral Artery Disease. Further review of the "Non-Pressure Wound and Skin Condition Documentation" forms, dated 8/2/11 and 8/10/11, revealed identification of a rash on the resident's right and left axilla and a hematoma identified on the resident's right lower abdomen. According to the documentation on the forms, the physician was not notified, nor were there orders for treatment.  An interview with Licensed Practical Nurse (LPN) #3, on 10/21/11 at 1:55 P.M., revealed LPN # 3 conducted the skin assessment, on 08/10/11, and documented the presence of the rash and hematoma. According to LPN # 3, she "thought"	F 157	4. The 24 hour shift report will be reviewed by the Unit Managers, Director of Nursing or Assistant Director of Nursing during the morning clinical meeting to determine if a resident has had a change of condition and they physician notified. The medication administration records and skin assessment forms will be audited 2 times a week by the Director of Nursing, Unit Manager or Assistant Director of Nursing to identify change in condition and physician notification. The results of the review will be reported by the Director of Nursing monthly to the Performance Improvement Committee for 3 months for further review and recommendations..	12/02/11

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F 157	<p>Continued From page 3</p> <p>the resident already had treatment orders at the time she assessed the resident's skin and she did not notify the physician or the resident's family. LPN# 3 further stated the nurse who had conducted the initial skin assessment, on 08/02/11, was no longer employed at the facility.</p> <p>An interview with the Unit Manager, on 10/21/11 at 2:35 P.M., revealed the nurse conducting the assessment should have notified the physician of the change in resident # 24's skin condition. The Unit Manager further stated she was responsible to monitor the nursing staff and that she, "tried to check to see they were doing skin assessments." The Unit Manager also stated she was not the Unit Manager at the time the incident occurred.</p> <p>2. Record review revealed Resident #26 was admitted to the facility, on 07/11/08, with diagnoses which included Chronic Airway Obstruction, Shortness of Breath and Hypothyroidism.</p> <p>A review of the physician's orders, dated October 2011, revealed an order for Advair Diskus 500/50 micrograms (MCG)/dose Aerosol Powder Breath Activated Inhalation twice a day everyday (BID) at 7:00 AM and 4:00 PM.</p> <p>A review of the Medication Administration Record (MAR), dated October 2011, revealed on 10/12/11, on 10/13/11, on 10/14/11, and on 10/15/11, staff circled their initials at the time the Advair Diskus was due to be administered at 7:00 AM, and on the 10/12/11 and 10/13/11, staff circled their initials for the 4:00 PM dose of the Advair Diskus.</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>Interview with Registered Nurse (RN) #2, on 10/19/11 at 11:15 AM, revealed if a dose of medication was not given, the nurse should initial the block and circle their initials. The nurse should document the reason the medication was not administered on the MAR and if a medication tech was responsible for the medication administration, they should notify the charge nurse.</p> <p>Review of nurses notes, dated 10/09/11 through 10/20/11, revealed no documented evidence the facility notified the physician regarding the fact the Advair Diskus was unavailable for administration, on 10/12/11, on 10/13/11, on 10/14, and on 10/15/11. Additionally, the record review revealed no documented evidence the facility notified the physician regarding the fact the Advair Diskus was administered late, on 10/19/11.</p> <p>An interview with Certified Medication Technician (CMT) #1, on 10/19/11 at 9:05 AM, revealed she was aware the medication was given outside of the required time frame. She stated she started the medication pass late and the breakfast trays were passed to the residents before she could begin the medication pass. CMT #1 stated the nurse on the unit was having the resident's medication times changed to be administered after breakfast and the Advanced Practice Registered Nurse (APRN) ordered the medication time changes.</p> <p>Further review of the MAR, dated October 2011, revealed no time changes for the administration of the Advair Diskus.</p> <p>An interview with Registered Nurse (RN) #2, on</p>	F 157			

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F 157	Continued From page 5 10/19/11 at 1:50 PM, revealed she was the unit manager for two wings in the facility. The CMT should let the charge nurse know if they are having issues with the medications and the charge nurses should inform the unit manager. The unit manager should notify the Director of Nursing (DON) of the identified problem. She revealed she was not aware the physician was not contacted. Each time the medication was due and it was unavailable, the nurse should have informed the physician. She stated the nurses had not notified the physician regarding the missed doses of medication. Additionally, RN #2 was not informed CMT #1 was late administering medication for Resident #26, on 10/18/11, and the physician was not contacted.	F 157		
F 281 SS=D	An interview with the APRN, on 10/21/11 at 10:55 AM, revealed she became aware of the failure to administer the inhaler for four days, on 10/19/11. She stated staff need to notify her if a medication was not given, refused or late.  483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review to include policy review, It was determined the facility failed to ensure physician's orders were implemented for two residents (#26 and #27), not in the selected sample, related to medication administration. On 10/19/11, the Certified Medication Technician (CMT) #1	F 281	1. The Physician was notified on 10/19/2011 of administration of medications for residents #26 and #27 by the Unit Manager with no new orders received.  2. Administration of medication based on physician orders was reviewed by the Unit Managers on 10/19/2011 and no other residents were affected.	

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F 281	<p>Continued From page 6</p> <p>administered medications ordered to be administered at 7:00 AM at 8:53 AM for Resident #28 and ordered for administration at 8:00 AM at 9:37 AM, for Resident #27.</p> <p>The findings include:</p> <p>A review of the policy, "Administration of Medication", dated 10/15/05 and revised 04/01/08, revealed medications were to be given at the time ordered, or within 60 minutes before or after the designated time, except medications ordered before meals (AC) or after meals (PC), or as specifically ordered by physician.</p> <p>I. Record review revealed Resident #28 was admitted to the facility, on 07/11/08, with diagnoses which included Chronic Airway Obstruction, Shortness of Breath and Hypothyroidism.</p> <p>Observation during a medication pass, on 10/19/11 at 8:53 AM, revealed Certified Medication Technician (CMT) #1, administered Advair Diskus one puff, Spiriva Inhalation, Meloxicam 15 milligrams (mg), Aspirin 325 mg, Cymbalta 120 mg, Colace 240 mg, Lactulose 30 milliliter (ml) and Levothyroxine 100 micrograms (mcg) for Resident #26.</p> <p>A review of the physician's orders, dated October 2011, revealed an order for 7:00 AM medications included; Levothyroxine Sodium 100 micrograms (mcg); Lactulose (stool softener) 10 grams (gm)/ 15 milliliters (ml) give 30 ml every day; Cymbalta (antidepressant) 120 milligrams (mg) daily; Docusate Calcium (stool softener) 240 mg daily; Aspirin EC ( 325 mg) daily and Advair Diskus</p>	F 281	<p>3. Licensed nursing staff were re-educated by the Staff Development Coordinator on 11/7/2011 regarding physician notification if medication not administered at time ordered. The Certified Medication Technicians were re-educated by the Staff Development Coordinator on 11/7/2011 regarding notification to the charge nurse if medication not administered at time ordered.</p> <p>4. The medication administration records and physician orders will be reviewed monthly by the Director of Nursing Services, Assistant Director of Nursing Services, or Unit Managers to ensure timely medication administration based on physician orders. The results will be reported by the Director of Nursing to the Performance Improvement Committee for 3 months for further review and recommendations.</p>	12/02/11

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F 281	<p>Continued From page 7</p> <p>500/50 MCG/dose Aerosol Powder Breath Activated Inhalation, twice a day everyday (BID), at 7:00 AM.</p> <p>Review of the Medication Administration Record (MAR), dated October 2011, revealed on 10/12/11, on 10/13/11, on 10/14/11 and on 10/15/11, staff circled their initials at the time the Advair Diskus was due to be administered at 7:00 AM. On the 10/12/11 and 10/13/11, staff circled their initials for the 4:00 PM dose of the Advair Diskus. Additionally, CMT #1 did not document on the MAR the time she administered the resident's medication.</p> <p>Interview with Registered Nurse (RN) #2, on 10/19/11, revealed CMT #1 did not make her aware she was late administering Resident #26's medication.</p> <p>An interview with Certified Medication Technician (CMT) #1, on 10/19/11 at 9:05 AM, revealed she was aware the medication was given outside of the required time frame. She stated she had an hour before or after the designated time to administer the medication. CMT #1 revealed she started the medication pass late and the breakfast trays were passed to the residents before she could begin the medication pass. CMT #1 stated she would notify the nurse on the unit when medications were given late.</p> <p>An interview with Registered Nurse (RN) #2, on 10/19/11 at 1:50 PM, revealed she was the unit manager for two wings in the facility (D &amp; E). The CMT should let the charge nurse know if they are having issues with the medication administration and the charge nurses should inform the unit</p>	F 281			

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F 281	<p>Continued From page 8</p> <p>manager. The unit manager should notify the Director of Nursing (DON). She revealed she was not aware the physician was not contacted. Each time the medication was due and it was unavailable, the nurse should have informed the physician and the nurses did not inform the physician about the missed doses of medication. Additionally, RN #2 was not informed CMT #1 was late administering Resident #26's medication, on 10/19/11, and the physician was not contacted.</p> <p>An interview with the APRN, on 10/21/11 at 10:55 AM, revealed staff should call her and let her know when a medication was not given, refused or late. She revealed the staff did inform her regarding the Synthroid, but was not sure they mentioned the Advair Diskus being late.</p> <p>2. Record review revealed Resident #27 was admitted to the facility, on 06/01/06, with diagnoses which included Asthma, Anxiety, Hypertension and Depressive Disorder.</p> <p>Observation during a medication pass, on 10/19/11 at 9:38 AM, revealed CMT #1 administered Celexa 40 mg, Colace 100 mg two tablets, Exelon 4.6 mg patch, Lisinopril 5 mg tablet, Synthroid 100 mcg tablet for Resident #27. At 9:50 AM, Vitamin D-3 1000 units one tablet and Loratadine one tablet were given by CMT #1.</p> <p>Review of the MAR for October 2011 revealed medications ordered for 8:00 AM included Celexa 40 mg (antidepressant), Loratadine 10 mg (allergy), Docusate Sodium 200 mg (stool softener), Exelon 4.6 mg patch (for mild dementia medication), Lisinopril 5 mg (lowers blood</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>pressure), Synthroid 100 mcg, Vitamin D 1000 units and Artificial Tears one drop in affected eye. The CMT initiated the medications as if administered when they were ordered and did not document on the MAR the actual time she administered the residents medication.</p> <p>Interview with CMT #1, on 10/19/11 at 9:40 AM, revealed she was aware she had administered the resident's medication late. She revealed the medications were due at 8:00 AM and the earliest she could administer the medication was 7:00 AM and the latest was 9:00 AM. CMT #1 she did not have problems giving the resident's medication as ordered. She stated the trays were delivered before she started the medication pass and she could not administer medications while the residents were eating their breakfast.</p> <p>An interview with Registered Nurse (RN) #2, on 10/19/11 at 1:50 PM, revealed she was the unit manager for two wings in the facility (D &amp; E). She stated the CMT should let the charge nurse know if they are having issues with the medications and the charge nurses should inform the unit manager. The unit manager would let the Director of Nursing (DON) know about the problem. RN #2 revealed she was not aware CMT #1 was late administering Resident #27's medication, on 10/19/11.</p> <p>An interview with the Director of Nursing (DON), on 10/19/11 at 2:45 PM, revealed she was not informed by the unit manager the medications were given late. Medications were expected to be given as ordered.</p> <p>An interview with the APRN, on 10/21/11 at 10:55</p>	F 281		

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F 281	Continued From page 10 AM, revealed staff should let her know if a medication was given late. She stated staff called her regarding the Synthroid being given late, however, she was unsure whether she was informed about all the medications being given late.  An interview with Licensed Practical Nurse (LPN) #3, on 10/21/11 at 11:20 AM, revealed CMT #1 made her aware she was late giving the residents their medication. She stated the times were changed and an order was obtained from the APRN to change the times.  Review of the MAR for Resident #27, conducted on 10/21/11, revealed the times noted for administration of the medication was 8:00 AM.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, which included review of policy and procedure, it was determined the facility failed to ensure residents who were incontinent of bladder	F 315	1. RN #1 was re-educated on incontinence care process by the Director of Nursing Services on 10/21/2011. Resident # 14 had incontinence care provided by the nursing staff on 10/20/11.  2. Observation of incontinence care was conducted by the Unit Managers on 10/21/11 and no other residents were identified to have been affected.	

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F 315	<p>Continued From page 11</p> <p>received appropriate treatment and services to prevent infection for one resident (#14), in the selected sample of 24.</p> <p>The findings include:</p> <p>A review of the policy, "Continence Management Program", revised 12/10, revealed the facility was responsible to ensure residents with or without a catheter received appropriate care and services to prevent infections, to the extent possible.</p> <p>A record review revealed Resident #14 was admitted to the facility, on 08/06/08, with diagnoses to include Obesity. A review of the significant change Minimum Data Set (MDS), dated 09/20/11, revealed the facility assessed the resident as severely cognitively impaired and required extensive assist of two staff for hygiene. The facility assessed the resident as incontinent of bowel and bladder.</p> <p>An observation of incontinent care for Resident #14, on 10/20/11 at 10:50 AM, revealed Registered Nurse (RN) #1 used a washcloth with soap to cleanse under the resident's breasts. She placed the washcloth on the resident's bedside table. The resident was observed to have a thick cream to his/her perineal area. RN #1 used the soiled washcloth to cleanse the resident's perineal area. Afterwards, she placed the washcloth back on the bedside table. The resident was repositioned on his/her side, and RN #1 used the same soiled washcloth to cleanse the resident's buttocks. After incontinent care, RN #1 was observed to remove the washcloth from the bedside table, however, RN #1 did not clean the bedside table, prior to exiting the resident's room.</p>	F 315	<p>3. Licensed and certified nursing staff were re-educated on the procedure for incontinence care by the Staff Development Coordinator on 11/7/2011. Licensed and certified nursing staff will perform a skills check off of incontinence care conducted by the Staff Development Coordinator by 12/1/11.</p> <p>4. Observations of 5 residents receiving incontinence care will be performed by the Director of Nursing Services, Assistant Director of Nursing Services or Unit Managers monthly for the next 3 months. The results will be reported by the Director of Nursing to the Performance Improvement Committee for further review and recommendations.</p>	12/02/11

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F 315	Continued From page 12  An interview with RN #1, on 10/20/11 at 11:10 AM, revealed she was aware she should not have placed the soiled washcloth on the resident's bedside table. She revealed the same washcloth was used, however, she had cleansed the resident from "clean" to "dirty."  An interview with the Director of Nursing (DON), on 10/20/11 at 1:15 PM, revealed she expected staff to use a clean washcloth when cleansing different areas of the body. She revealed soiled washcloths should be placed in a bag, not on the resident's bedside table. She expected staff to clean the bedside table after soiled linen was removed.	F 315		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, It was determined the facility failed to ensure trash and refuse was disposed of properly. The facility failed to ensure dumpsters were placed on a smooth, washable, nonabsorbent surface, as required by the Kentucky Retail Food Code (KRS 217.127) and failed to ensure trash was properly contained.  The findings include:  Observation on 10/18/11 at 10:00 AM, revealed three (3) dumpsters were located outside the	F 372	1. The tires, wheel, cardboard boxes, floor tiles, wooded framed chair, wooden pallets and other debris were picked up and discarded by the Maintenance Department on 10/19/11. The Administrator instructed the Owensboro Sanitation Department on 10/20/11 to place the dumpsters on the asphalt parking area adjacent to the graveled area.  2. The areas outside the facility around the dumpster area were checked for any other debris by Maintenance Staff and the Administrator on 10/19/11.	

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F 372	<p>Continued From page 13</p> <p>facility on a loose gravel surface. In addition, observation, on 10/18/11 at 10:00 AM, revealed two (2) tires, one (1) tire contained a rusted metal wheel, lying on the ground adjacent to the dumpsters. Additionally, two (2) large rain soaked card board boxes were observed behind the dumpsters. Further observation revealed one (1) large wooden framed chair, eighteen (18) wooden pallets and a large pile of broken pieces of kitchen floor tiles were on the ground, adjacent to the dumpsters, along with disposable gloves and other litter.</p> <p>An interview with the facility Maintenance Director, on 10/19/11, at 3:00 PM, revealed the facility did not have a policy on disposal of waste and refuse.</p> <p>An interview with the Administrator, on 10/19/11 at 4:00 PM, revealed the administrator was unaware the dumpsters were required to be placed on a smooth, nonabsorbent, washable surface.</p> <p>An interview was conducted with the facility Maintenance Director, on 10/19/11 at 3:00 PM, revealed the the maintenance department staff were responsible for keeping the dumpster area clean. Additionally, the facility had a schedule with preplanned exterior/interior inspections and cleaning. The Maintenance Director stated the floor tiles were discarded when the kitchen floor tiles were installed in January of 2011 and he did not know why the discarded tiles had not been placed in the dumpster(s) to be picked up by the trash collectors. The Maintenance Director stated he was unaware the dumpsters should be placed on a smooth nonabsorbent washable surface.</p>	F 372	<p>3. The Dietary Department and Maintenance Department staff were re-educated by the Administrator on 10/19/11 on maintaining a debris free area around the dumpster sight and that the dumpsters need to be placed on a smooth, washable, nonabsorbent surface.</p> <p>4. Weekly audits of the dumpsters and areas around the dumpsters will be completed by the Dietary Manager and Maintenance Director to ensure trash and refuse is disposed of and the dumpsters are placed on smooth, washable, nonabsorbent surfaces. The results will be reported by the Maintenance Director to the Performance Improvement Committee for further review and recommendations for the next 3 months.</p>	12/2/11

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F 441 SS=E	<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. (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>	F 441	<p>1. Residents number 3 and 28 are no longer in facility.</p> <p>2. Residents were assessed by the Infection Control Nurse to determine isolation precautions needed on 10/21/11. Culture reports were reviewed by the Unit Managers and infection control nurse on residents who had cultures ordered on 10/21/11, with no other residents affected. Type of isolation precautions for identified residents were update on the certified nursing assistant care card and isolation precaution cards were by the personal protective equipment container by the Unit Managers on 10/21/11.</p>	

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F 441	Continued From page 15  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain an infection control program to ensure a safe, sanitary environment and to help prevent the development and transmission of disease and infection for one resident (#3), in the select sample of 24 and one resident (#28), not in the select sample.  Resident #3 had physician orders for Contact Precautions, however, staff failed to implement the appropriate equipment and precautions.  Resident #28 had a sign above the resident's door, indicating "Isolation" precautions, however, the facility failed to ensure staff were knowledgeable of the type of precaution needed and failed to utilize any of the Personal Protective Equipment (PPE) provided.  Additionally, the facility failed to ensure staff consistently washed their hands and/or used sanitizer between resident care and during meal service.  The findings include:  A review of the facility's infection control policy, dated 10/09, revealed the facility utilized Standard Precautions for all residents when providing care, regardless of the diagnosis or suspected infection. In addition to Standard Precautions, the facility utilized Transmission-Based Precautions for residents who were known or	F 441	3. Re-Education on hand washing procedure and the isolation precaution process was provided to the nursing staff by the Staff Development Coordinator on 10/19/2011. Culture reports will be reviewed by the Director of Nursing, Assistant Director of Nursing, Unit Managers or Charge Nurse when obtained from lab to ensure precautions are in place as outlined in facility infection control policy.  4. Observation rounds will be completed weekly to ensure hand washing and isolation precautions are followed by the Director of Nursing and Infection Control Nurse. Observations will continue weekly times 4 weeks then monthly. Findings will be reported by the Director of Nursing monthly to the Performance Improvement Committee for review and further recommendations.	12/02/11

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F 441	Continued From page 16 suspected to be infected or colonized with infectious agents, including pathogens that require additional control measures to prevent transmission. The policy further stated the category of transmission-based precaution determined the type of PPE to be used. The particular type of PPE to be used was to be communicated to staff. Contact Precautions were to be used in addition to Standard Precautions for residents known/suspected to be infected by microorganisms that could easily be transmitted by direct or indirect contact such as Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Herpes (simplex or zoster) or Clostridium difficile. Contact Precautions included: Private room, if possible, if none available, may cohort residents infected with the same microorganism or if cohorting was not possible, maintain a separation of at least three (3) feet between the infected resident and all others. Wear clean gloves and gown when entering the room. Wear gloves and a gown for all interactions that may involve contact with the resident of potentially contaminated areas of the resident's environment. Change gloves and gown after each contact with infective material. Remove gloves/gown carefully and wash hands before leaving the room. Limit resident movement and when possible, dedicate equipment to single or cohorted residents.  1. A review of the medical record revealed Resident #3 was admitted to the facility, on 06/03/10, with diagnoses which included Diabetes Mellitus and Alzheimer's Disease. A review of the Minimum Data Set (MDS) assessment, dated 08/17/11, revealed Resident #3 developed a	F 441		

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F 441	<p>Continued From page 17 pressure sore on the coccyx.</p> <p>Review of the nurses' notes, dated 10/11/11, revealed a wound culture was obtained and the results received by the facility, indicated Resident #3 was infected with Methicillin Resistant Staphylococcus Aureus (MRSA). The physician was notified, orders were received and contact precautions were initiated.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 10/21/11 at 8:50 AM, revealed the nurse who received a positive culture report was responsible to notify the physician, family, Infection Control Nurse and to initiate appropriate precautions for the infectious agent. LPN # 1 further stated the nurse was responsible to inform the staff of the additional care needs of the resident and she, "usually just told the aides about it."</p> <p>Observations, on 10/18/11 at 3:45 PM, revealed a container on the resident's door contained gloves, disposable gowns, masks, head covers and shoe covers. However, there was no information regarding the type of precautions to be utilized or the PPE necessary for this resident. Further observation revealed two (2) Certified Nursing Assistants (CNA) were inside the resident's room and in the process of assisting the resident with turning/repositioning and checking the resident for incontinence. Both CNAs were observed to be wearing gloves with no additional PPE in use.</p> <p>An interview with CNA #1, on 10/18/11 at 3:45 PM, revealed Resident # 3 did not require PPE and that the other resident in the room was the resident who was "on precautions".</p>	F 441		

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F 441	<p>Continued From page 18</p> <p>Observations, on 10/19/11 at 7:50 AM, revealed CNA #2 attempted to feed Resident #3. CNA #2 was observed attempting to feed the resident and did not wear any gloves or additional PPE.</p> <p>An interview with CNA #2, on 10/19/11 at 7:50 AM, revealed the CNA should check the Nursing Assistant Care Card each day, at the beginning of the shift, to identify care needs of the residents and to check for any changes or updates.</p> <p>A review of the Nursing Assistant Care Card, dated 10/11, revealed no documentation of any precautions to be taken during the care for Resident #3.</p> <p>Observations, on 10/19/11 at 10:00 AM, revealed Licensed Practical Nurse (LPN) #2 and a CNA were in Resident #3's room, providing wound care. LPN#2 and the CNA were observed to be wearing full isolation PPE, gown, gloves, mask, head covers and shoe covers.</p> <p>An interview with LPN #2, on 10/19/11 at 8:10 AM, revealed Resident #3 was on isolation precautions, due to MRSA of the resident's wound. LPN #2 further stated the Unit Manager and nurses were to update the Nursing Assistant Care Cards, as needed, whenever a change in care needs occurred.</p> <p>An interview with the Infection Control Nurse (ICN), on 10/20/11 at 2:45 PM, revealed the ICN was to be notified of any resident requiring any additional precautions. The ICN further stated the nurse on duty was responsible to obtain the PPE and inform the staff what type of precautions</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>were required. The ICN stated the staff knew which PPEs were required, based on the type of precautions ordered.</p> <p>Observations and interviews with the ICN present, on 10/20/11 at 3:10 PM, revealed CNA #3 stated she would use all the equipment in the PPE container, when delivering care. CNA #3 stated during the interview in the presence of the ICN, that she was unaware of the type of isolation precautions Resident #3 required. CNA # 3 stated she would use all included in the PPE kit.</p> <p>An interview with the ICN, on 10/20/11 at 3:35 PM, revealed staff should have known which equipment to use and the nurse on the floor should have added the guidelines to the nursing care plan and the nursing assistant care card.</p> <p>2. A review of the medical record revealed Resident #28 was admitted, on 10/25/08, with diagnoses to include Alzheimer's Disease and Chronic Airway Obstruction. On 04/30/11, the resident was diagnosed with MRSA, cultured from a wound to the left lower extremity (LLE.) A culture was repeated, on 08/03/11, and revealed, "scant growth" of MRSA. The quarterly MDS, dated 10/03/11, revealed Resident #28 had a venous or arterial (stasis ulcer) and required applications of a nonsurgical dressing and ointments and/or medications.</p> <p>A review of the "potential for alteration in skin integrity" care plan, dated 03/08/10, revealed the resident had a non-healing vascular wound to the LLE and required treatment, as ordered and was placed on contact isolation, effective 05/03/1, and the care plan was updated on 10/20/11.</p>	F 441		

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F 441	<p>Continued From page 20</p> <p>Review of the "wound infection" care plan, dated 05/05/11 and updated 10/03/11, revealed the nursing staff were to "observe the appropriate precautions." A review of the Nursing Assistant Care Card, for October 2011, required the assistance of two staff members to transfer and the resident was to receive baths per the unit schedule and was incontinent of bowel and bladder. There was no mention of isolation or contact precautions.</p> <p>Observations, on 10/18/11 at 11:26 AM and 3:38 PM; 10/19/11 at 7:40 AM and 12:00 PM; 10/20/11 at 9:00 AM and 3:40 PM and on 10/21/11 at 8:45 AM and 2:53 PM, revealed a small sign above the resident's name at the doorway entrance to the resident room, "Isolation 14 B." A container was hung over the resident's door which held gloves, gowns, masks, head and shoe covers, goggles and red bags. There was no signage to indicate the type of contact precautions to use with the resident or the resident's roommate or whether visitors needed to check with the nurse at the desk, prior to entering the room.</p> <p>An observation, on 10/21/11 at 8:45 AM, revealed CNA #6 exited Resident #28's room, without wearing any protective equipment. An interview with CNA #6, on 10/21/11 at 8:48 AM, revealed, if there was a sign on the resident's door for isolation, she would don a robe, gloves, foot covers, goggles and a head covering and she would do this for all residents who had an isolation sign on the door, no matter what type of isolation was identified. She stated she did not need to do this, at this time, because she only went into the room to ask another staff member a</p>	F 441			

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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		
(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 441	<p>Continued From page 21 question.</p> <p>Observation and interview with CNA #7, on 10/21/11, at approximately 8:45 AM, revealed the CNA was assisting Resident #28 with breakfast and was not utilizing any protective equipment. The CNA revealed when residents were on isolation, the staff were to take "extreme precautions," and don a gown, gloves, mask, footwear and a mask. The CNA stated she was unaware the resident she was assisting had a isolation sign on the doorway and stated, "No one has told me," and stated she thought it was against the law to post an isolation sign on the resident's door.</p> <p>An interview with RN #2, on 10/21/11 at 11:05 AM, revealed the nurse was unsure why Resident #28 was still on isolation precautions, as the nurse and the staff members had discussed the resident's legs had healed, yet the sign and the PPE remained on the resident's door. She stated the process for isolation or contact precautions was to obtain the ordered cultures of the bacteria, obtain an order from the physician for antibiotics and isolation, notify the family, put the information on the care plan and the CNA care plan, put cards on the resident's door and place a container of PPE on the door. The RN was unaware why there was no information regarding isolation included on the CNA care plan, and stated the CNA should have been provided information during report at shift change.</p> <p>3. Review of the policy for hand hygiene, dated 04/11, revealed "To prevent bacteria from being to others, you should wash your hands before treating a resident and after treating a resident,</p>	F 441		

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

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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 441	<p>Continued From page 22</p> <p>after contact with body fluids, and after contact with contaminated items such as linen and center equipment."</p> <p>Observation during a lunch meal service, on 10/18/11 at 12:05 PM, in the Restorative Dining room, revealed twelve residents being served by Certified Nurse Aides (CNA) #3 and CNA #10. The CNAs were observed serving food trays and opening the residents individual food containers, and touching residents clothing and personal items. The CNAs were observed to continue to serve the meals after touching the resident's personal clothing, without using hand sanitizer or handwashing.</p> <p>Observation revealed CNA #3 touched a blanket with her bare hands, which covered the resident's legs, which was soiled with urine. The CNA was observed to immediately pick up a resident's drinking glass and hand the glass to the resident, without using hand sanitizer or washing hands.</p> <p>An interview with CNA #3, on 10/19/11 at 9:30 AM, revealed she knew she was supposed to wash or sanitize her hands between resident contact. She further revealed she had hand sanitizer in her pocket, but "forgot to use hand sanitizer" and she "should have washed hands after touching the residents wet blanket."</p> <p>An interview with the Assistant Director of Nursing (ADON), on 10/19/11 at 7:55 AM, revealed "all CNAs should sanitize hands between resident contact."</p> <p>An interview with Director of Nursing (DON), on 10/18/11 at 2:30 PM, revealed "CNAs should</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
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F 441	<p>Continued From page 23</p> <p>always wash or sanitize hands between assisting residents"</p> <p>Observation during the breakfast meal service, on 10/19/11 at 7:25 AM, in the Restorative Dining room, revealed CNA #4 took a dirty tissue from a resident and threw the tissue away, and did not wash her hands or use hand sanitizer prior to assisting another resident with their meal. CNA #4 continued to assist three other residents prior to sanitizing her hands.</p> <p>An interview with CNA #4, on 10/19/11 at 7:50 AM, revealed she "should have used handwashing or hand sanitizer between assisting each resident." She further stated, she "got nervous and forgot to clean hands" between resident care.</p> <p>An interview with the ADON, on 10/19/11 at 7:55 AM, revealed CNA #4 " should have washed her hands after touching the dirty tissue and before going back to providing care to residents."</p> <p>An interview with DON, on 10/19/11 at 2:30 PM, revealed CNA #4 should not have touched the dirty tissue without washing her hands afterwards and she expected staff to wash their hands and CNAs in the Restorative Dining room should have washed or sanitized their hands between assisting each resident.</p> <p>4. An observation during the breakfast meal service on the D Wing, on 10/19/11 at 8:00 AM, revealed staff passed trays to residents without proper hand sanitation between the trays. Certified Nurse Aide (CNA) #1 passed eight trays without using hand sanitizer or washing her</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
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F 441	<p>Continued From page 24</p> <p>hands. CNA #2 passed seven trays without using hand sanitizer or washing her hands. Both staff members were observed setting up trays for the residents and repositioning residents in bed, and did not sanitize or wash their hands between residents.</p> <p>An interview with CNA #1, on 10/19/11 at 8:40 AM, revealed she had been made aware that day to sanitize or wash her hands after every two to three resident trays. She revealed sanitizer was available in the facility, but she "forgot" because she was so "busy."</p> <p>An interview with CNA #2, on 10/19/11 at 8:40 AM, revealed she was aware sanitizer should be used after every resident tray, but it had been a "crazy" morning.</p> <p>An interview with the Director of Nursing, on 10/20/11 at 1:15 PM, revealed she expected staff to use sanitizer after every resident tray.</p>	F 441			