

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

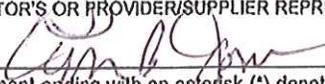
PRINTED: 02/05/2014
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/22/2014 |
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| NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029 |
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| F 000 | INITIAL COMMENTS A Recertification Survey was conducted on 01/20/14 through 01/22/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of "E". | F 000 | | |
| F 253 SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide the housekeeping services necessary to maintain a sanitary, orderly and comfortable environment for one (1) of seventeen (17) sampled residents (Resident #1). Housekeeping services were not provided prior to a room change for Resident #11. The findings include: A review of the facility policy titled, "Environmental Services Guidelines", undated, revealed a terminal room cleaning should be performed when a resident is discharged from the unit. The cleaning includes cleaning of the bed frame, mattress, bedside stand, closet (inside and out), overbed table, chairs, lights, walls and bathroom. They should be aggressively cleaned with disinfectant/germicide, and the unit will be made up in anticipation of a new admission. | F 253 |  <p>1. Room number 126 was cleaned by housekeeping staff on 1/20/2014 after Resident 11 had finished eating her lunch and the housekeeping supervisor was interviewed by the state surveyor. Resident 11 was out of the room while housekeeping staff cleaned the room. Unsampled resident A from room 124A was in the dining room when her furniture was moved by maintenance into room 126A. She remained in the dining room while room 126 was cleaned. Resident 11 moved to room 102A later that day after it had been cleaned prior to her move. The Maintenance Supervisor was verbally educated on 1/20/2014 by the Director of Nursing (DON) to never begin moving a resident's belongings into a room without first checking with housekeeping to ensure the room had been cleaned. They were also educated to never move belongings into a room during meal times. The Charge Nurse, a Licensed Practical Nurse (LPN), on duty was verbally educated by the DON on 1/20/2014 that she must ensure housekeeping is notified of any room changes and ensure the room is cleaned prior to any belongings of the resident being placed in the room and the room change/cleaning shouldn't occur during meal times.</p> <p>2. All residents have the potential to be affected by the deficient practice.</p> <p>3. A mandatory In-service training for all maintenance staff and licensed nurses will be conducted on two dates, 2-20-2014 and 2-21-</p> | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE ADMINISTRATOR | (X6) DATE 2/13/14 |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 253 | Continued From page 1 Observation on 01/20/14 at 11:45 AM revealed the maintenance staff was moving unsampled Resident A's furniture from room 124 A into room 126 A where Resident #11 was sitting eating his/her lunch. Interview with the maintenance staff at the time revealed Room 126 had not been cleaned prior to Resident A being moved in there. Interview with the Housekeeping/Laundry Supervisor, on 01/20/14 at 11:54 AM, revealed she was aware from morning meeting that Resident #11 had requested a room change but had not been made aware that a change had been made. She revealed the unit supervisor is responsible for notifying housekeeping of any move. She stated when one resident is moved out of a room, that room is cleaned and the dresser and closet is wiped out and if a resident leaves the room permanently the entire room is wiped down. She stated she expected housekeeping staff to have cleaned the room before another resident was moved into the room. Interview, on 01/20/14 at 12:37 PM with Registered Nurse (RN) #2, revealed housekeeping should have been notified by the nurse on duty when it was determined the resident was going to move to another room. She stated the room should have been completely cleaned prior to another resident moving into that room. | F 253 | 2014. The DON will provide the in-service related to ensuring housekeeping services are provided to maintain a sanitary residence. In-service content to include: Proper notification of any room changes or discharges from the unit. The licensed Charge Nurse on duty is to notify housekeeping immediately upon knowledge of any room changes or discharges from the unit. The Charge Nurse should advise Housekeeping of the time the room change is expected to occur to allow them ample time to schedule the room cleaning so it doesn't interfere with the resident's meal time. Maintenance staff will be educated to never move belongings into a room without first checking with housekeeping to ensure the room has already been cleaned and not to move belongings into the room during the residents meal time. 4. The Social Services Director will monitor all room changes or discharges from the unit for 2 months to ensure that Housekeeping has been properly notified. The Housekeeping Supervisor will monitor all room changes or discharges from the unit for 2 months to ensure maintenance staff is checking with housekeeping prior to moving resident's belongings and the room has been cleaned. The LPN Quality Improvement Coordinator or Quality Improvement Committee team member will monitor for continued compliance to ensure proper notification to housekeeping and from maintenance is being done and rooms are cleaned prior to any room changes or discharges from the unit during a time that doesn't interfere with the residents meal times by randomly checking 5 room changes or discharges per month. Any non-compliance is to be reported to the DON. The DON/Designee will re-educate the staff member involved in any found non-compliance followed by discipline, if indicated, per guidelines of the personnel policy handbook. 5. Completion Date: 2-22-2014 | |
| F 334 SS=D | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- | F 334 | | 2-22-2014 |

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| F 334 | <p>Continued From page 2</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse</p> | F 334 | <p>1. On 1-22-2014 a late entry was recorded by the LPN Infection Control/Quality Improvement Nurse on Resident #6 immunization record reflecting her refusal of the influenza vaccination for 2013. The DON verbally educated the LPN Infection Control/Quality Nurse on 1/22/2014 that any refusal of the influenza vaccine must be documented on the resident's immunization record annually.</p> <p>2. All residents have the potential to be affected by the deficient practice.</p> <p>3. All residents immunization records are being reviewed by the LPN Infection Control/Quality Nurse and RN Unit Supervisors to ensure any refusals are documented. A mandatory in-service is scheduled for the dates of 2-20-14 and 2-21-14 for all licensed nurses. In-service will be conducted by the DON. In-service content to include procedure and protocol related to proper documentation of influenza immunizations and refusals. Residents must be offered the influenza vaccine annually between the dates of October 1 through March 31 unless it is medically contraindicated or the resident has already received an influenza vaccine during that time period. Documentation of the vaccine administration, refusal, or medical contraindication must be entered on the resident's immunization record. All vaccine refusals must also be documented as a narrative entry in the nurse's notes.</p> <p>4. The RN Unit Supervisors will review the resident's immunization records within 7 days of all new admissions through the influenza vaccination time frame for the current year, March 31, 2014, to monitor for continued compliance. Annually, all residents immunization records will be reviewed by the</p> | |
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| F 334 | <p>Continued From page 3 immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the resident face sheet, nurse's notes, immunization record and facility policy it was determined the facility failed to document a refusal of an Influenza vaccine for Resident #6.</p> <p>The findings include: Review of the facility policy titled, "Influenza", not dated, revealed the facility recommended flu vaccines to residents and/or resident responsible parties and refusals should be documented in the resident's medical record.</p> | F 334 | <p>RN Unit Supervisors during the vaccination time frame of October 1 through March 31 to ensure compliance is sustained. Any non-compliance is to be reported to the DON. The DON will re-educate the staff member involved in any found non-compliance followed by discipline, if indicated, per guidelines of the personnel policy handbook.</p> <p>5. Completion Date: 2-22-2014</p> | 2-22-2014 |
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| F 334 | <p>Continued From page 4</p> <p>Review of the face sheet revealed the facility readmitted Resident #6 on 05/27/12 with diagnoses which included Depressive Disorder.</p> <p>Review of Resident #6's Immunization Record and nurses notes revealed there was no documentation an Influenza vaccine was given or a refusal of Influenza vaccination for 2013.</p> <p>Interview with the Infection Control/Quality Improvement Nurse, on 1/21/14 at 2:30 PM, revealed she did not document Resident#6's refusal of the Influenza Vaccine for 2013 in the resident's chart.</p> <p>Interview with the Director of Nursing (DON), on 01/22/14 at 12:53 PM, revealed refusal of immunizations should be documented on the Immunization Record and nursing notes annually.</p> | F 334 | | |
| F 425 SS=E | <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation</p> | F 425 | <p>1. RN #1 removed all expired drugs from the Emergency Drug Box and contacted the pharmacy for replacement medications on 1/22/2014 after interview with the state surveyor. RN #1 also counted and initiated a Controlled Drugs-Count Record for the Ativan that was stored in the locked narcotic box inside the refrigerator. The DON verbally in-serviced licensed nurses and medication aides on duty on 1-22-2014 that all Narcotics must be counted and signed on the Controlled Drugs-Count record by both the on coming and off going nurse or medication aides. The Pharmacy was contacted by The DON on 1/22/2014 regarding the expired drugs and the need for them to manage the Emergency Drug Box medications and maintain it with non-expired drugs.</p> | |

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| F 425 | <p>Continued From page 5</p> <p>on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy for "Controlled Substances", ER Box Sign Out Sheet, and Controlled Substances Use Record, it was determined the facility failed to ensure the pharmacy provided an Emergency Drug Kit (EDK) that was monitored for expired medications and the expired medications were removed from the EDK. In addition, the facility failed to ensure narcotics, locked in the EDK Medication Room Refrigerator, were counted every shift.</p> <p>The findings include:</p> <p>Review of the facility policy "Controlled Substances", undated, revealed staff assigned for the medication administration must count controlled drugs at the end of each shift. The staff coming on duty and the person going off duty, must make the count together and document the narcotic count. They must report any discrepancies to the Director of Nursing (DON,) or designee. Interview with Registered Nurse (RN) #1, on 01/22/14 at 10:50 AM, revealed the RN was responsible to check the expiration dates on the EDK, as the facility had recently changed pharmacies and there was no agreement or policy, with the pharmacy, to perform this service.</p> <p>1. Observation of the medication Room on the</p> | F 425 | <p>2. All residents have the potential to be affected by the deficient practice.</p> <p>3. The Pharmacy has developed an Emergency Drug Box Protocol. A mandatory in-service is scheduled for the dates of 2-20-2014 and 2-21-2014. In- service will be conducted by the DON. In-service content to include education on the new pharmacy protocol which includes how to properly remove drugs from the box so the drugs will be replaced by the pharmacy, and the protocol for how audits, inventory, and expiration dates of the medications in the box will be handled. All drugs in the Emergency Drug Box will have its own inventory sheet. This sheet will be documented on when each drug is removed and replaced, along with time, date, patient name, and the person removing or replacing the drug. The pharmacist will perform quarterly audits and remove any drug with an expiration date that falls within the next 6 six months of the date the audit is performed And replace it with new medications with a longer than 6 months expiration date. A log will be kept by the pharmacist to document the audits. Education will also include the proper protocol for counting narcotics and the documentation to prove the count was completed. All Narcotics in the facility, including the locked emergency drug box in the refrigerator, must be counted and signed on the Controlled Drugs-Count record by both the on coming and off going nurse or medication aides each shift. Any narcotic that is administered must be documented on the residents Controlled Substance Use Record. Documentation to</p> | |
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| F 425 | <p>Continued From page 6</p> <p>West Wing, on 01/22/14 at 10:50 AM, revealed RN #1 had expired medications in the EDK to include: One (1) ampule of Vitamin K, expired on October 2013; Four (4) tablets of Levaquin 250 Milligrams (mg,) expired April 2013; and one (1) tablet of Clonidine 0.1 mgs, expired 11/20/13.</p> <p>Interview, on 01/22/14 at 10:55 AM, with RN #1, revealed there was only one EDK, in the facility, and this was kept on the West Wing and she was responsible to check the expiration dates and had not had the time to go through and discard the medications.</p> <p>Interview with the DON, on 01/22/14 at 12:15 PM, revealed the pharmacist was under the impression the facility was keeping up with the EDK expired medications and the DON thought the pharmacy was taking care of this.</p> <p>2. Observation of the Medication Room on the West Wing, on 01/22/14 at 11:00 AM, revealed four (4) vials of Ativan two (2) mg per milliliter (ml,) were locked, in a separate box, in the refrigerator and had not been counted since 01/18/14.</p> <p>Review of the "ER Box Sign Out Sheet," dated 01/18/14 at 6:30 PM, revealed there were "four and one-half vials left." Review of the "Controlled Substance Use Record," dated 01/01/14, revealed there were five (5) vials of Ativan in the EDK.</p> <p>Interview with RN #1, on 01/22/14 at 11:05 AM, revealed the on coming licensed nurse and the off going licensed nurse should have been counting the narcotics in the EDK, in the refrigerator, with every shift change.</p> | F 425 | <p>include the date, time, amount given, the amount left after administration, and the staff members signature who administered the drug.</p> <p>4. The DON or Designee will monitor for compliance of the facility maintaining accurate narcotic count records by viewing the Controlled Substance Use Records of all Narcotics daily five days per week for two months followed by weekly visual checks to ensure compliance is sustained. The pharmacy audit logs maintained by the pharmacist will be reviewed quarterly by the DON to ensure compliance is sustained. Any employee noted to be involved in any non-compliance will be re-educated followed by discipline, if indicated, per the personnel policy handbook. Any re-education and or discipline will be conducted by the DON.</p> <p>5. Completion Date: 2-22-2014</p> | 2-22-2014 |
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| F 425 | Continued From page 7 Interview with the Staff Development Coordinator (SDC), on 01/22/14 at 12:30 PM, revealed the nurses, from each shift, were to count the narcotics together, at shift change and the narcotics in the EDK, should have been counted at this time. Interview with the DON, on 01/22/14 at 12:20 PM, revealed the EDK narcotics should have been counted every shift and she was responsible to monitor this was being completed. | F 425 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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 | F 441 | 1. The nebulizer machines that were on the floor in rooms in 201 and 210 were removed from the floor. The machines were cleaned and stored in the medication room as resident's nebulizer treatments were no longer ordered by the physician. LPN #1 was verbally in-serviced on 1-22-2014 by the DON on proper protocol for storage and use of nebulizer machines related to infection control. The nasal cannula tubing was removed and discarded from the oxygen tank stored on the back of the wheelchair outside the conference room door on East Wing. The oxygen tank and regulator was removed from the chair, sanitized, and placed in oxygen storage rack in the medication room storage area. 2. All residents have the potential to be affected by the deficient practice. All rooms and hallways were visually inspected by the DON on 1-23-2014 for any improper storage of nebulizer machines, mouthpieces/masks, oxygen tanks, or tubing to identify any other residents that may be immediately affected by the deficient practice. | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 01/22/2014 |
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| NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029 | | |
| (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 8</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy it was determined the facility failed to store two nebulizer machines, tubing and one oxygen cannula in a sanitary manner to prevent the transmission of infection and disease.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, "Nebulizer Breathing Machine Therapy Policy", not dated, revealed staff should disassemble equipment and clean nebulizing unit after each use. Each resident should have his/her own nebulizer machine, tubing, mouth piece, or mask, and it should be covered and stored in the nebulizer machine. The medication container should be rinsed with warm water after each use. Mask and tubing should be changed weekly.</p> <p>Observations on 01/20/14 at 11:45 AM, 12:41 PM, and 4:20 PM in room #210 revealed two nebulizer machines on the floor, a nebulizer machine, tubing and mouthpiece was on floor in</p> | F 441 | <p>3. A mandatory in-service for all nursing staff is scheduled on the dates of 2-20-14 and 2-21-2014. The DON will conduct the in-service. In-service content to include training on proper procedure and protocol for infection control maintenance related to storage, use, and cleaning of the nebulizer machines, oxygen tanks, and tubing. Nursing staff will be educated on the Nebulizer Therapy Policy: Each resident must have his/her own machine, tubing, mouthpiece, or mask. The medication container should be rinsed with warm water after each use. The machine and mouthpieces or masks should be covered and stored with the nebulizer machine on the resident's dresser or over bed table when not in use. The tubing, mouthpieces, or masks are to be changed weekly. Nebulizer machines or tubing should never be in the floor or have the tubing and mouthpiece in a dresser drawer. After nebulizer therapy is discontinued per physician orders all tubing, mouthpieces, and masks should be discarded. The nebulizer machine should be removed from the room immediately after the last ordered treatment, sanitized, and notify the supplier for pick up of the machine. Nursing staff will be also be educated on proper removal and storage of oxygen tanks and tubing. When oxygen is no longer in use the Charge Nurse should immediately discard the oxygen tubing and store the oxygen tank in the designated area. Empty oxygen tanks are to be stored in the soiled utility room. Non-empty tanks and regulators should be disinfected and stored in the medication room. Charge Nurses are responsible for ensuring the nebulizers, mouthpieces/masks, tubing, nasal cannulas, and oxygen tanks are stored and used in a sanitary manner that will prevent the transmission of infection.</p> | | |

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

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| NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029 | | |
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| F 441 | <p>Continued From page 9</p> <p>Room 201-1 , and a nebulizer machine was on the floor with tubing and mouth piece hanging out of top drawer of bedside table in room 201-2 .</p> <p>Interview, on 1/20/14 at 5:30 PM with Licensed Practical Nurse (LPN) #1, revealed nebulizer machines should not be on the floor. LPN #1 revealed the tubing should not go in the top drawer because they are dirty and she had not been in the room today.</p> <p>Interview, on 1/22/14 at 12:53 PM with the Director of Nursing (DON), revealed nebulizer machines should be stored on the dresser or over the bed table after it had been cleaned and covered with plastic bag.</p> <p>2. Observation on 01/20/14 at 11:30 AM and 4:30 PM, on 01/21/14 at 10:00 AM and 5:00 PM and on 01/22/14 at 12:30 PM revealed a portable oxygen tank stored on the back of a wheelchair outside conference room door on the East Wing with a nasal cannula attached. Further observation revealed dried brown particles adhering to the nasal prongs and "Y" portion of the tubing.</p> <p>Interview with the Director of Nursing (DON), on 01/22/14 at 12:55, revealed when an oxygen tank is not in use by a resident, the nasal cannula tubing should be discarded and the tanks should be returned to the designated oxygen storage area in the medication room. The DON stated the resident who had resided in the room adjacent to the East Wing conference room had been sent to the hospital on 01/16/14.</p> | F 441 | <p>4. The Charge Nurses on each wing will do a walk through daily on their shift to monitor for any improper storage or use of nebulizer machines, mouthpieces/masks, tubing, or oxygen tanks. The RN Unit Supervisors will visually inspect all rooms and hallways of their wing for any improper storage or use of nebulizer machines, mouthpieces/masks, tubing, or oxygen tanks weekly for two months to monitor for continued compliance. Thereafter, the LPN Staff Development Coordinator will visually inspect all rooms and hallways for any improper storage or use of nebulizer machines, mouthpieces/masks, oxygen tanks, or tubing weekly to ensure compliance is sustained. Any non-compliance will be reported to the DON. The DON will re-educate the staff member involved in any non-compliance followed by discipline, if indicated, per guidelines of the personnel policy handbook.</p> <p>5. Completion Date: 2-22-2014</p> | 2-22-2014 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 01/21/2014 |
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| K 000 | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1972.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1972, and upgraded in 2010 with 16 smoke detectors and 3 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1972 and upgraded in 2011.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 01/21/14. Calvert City Convalescent Center was found in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Ninety-Five (95) beds with a census of Eighty-Five (85) on the day of the survey.</p> <p>The findings that follow demonstrate compliance with Title 42, Code of Federal Regulations,</p> | K 000 | | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE ADMINISTRATOR | (X6) DATE 2/13/14 |
|--|------------------------|----------------------|

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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| K 000 | Continued From page 1 483.70(a) et seq. (Life Safety from Fire). | K 000 | | |
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