

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2013
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NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSDALE, KY 42164
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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 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the POC, the facility was deemed to be in compliance with Federal Regulations on 08/23/13, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164
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F 000	INITIAL COMMENTS A recertification/abbreviated survey ((KY #20447 and KY #20473) was conducted on 07/29/13 through 07/31/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E." KY #20447 was unsubstantiated with unrelated deficiencies cited and KY #20473 was unsubstantiated with no deficiencies cited.	F 000	This plan of correction is offered as an attempt to provide the highest level of quality services possible to our residents and is not an admission that the deficiencies cited are correct.	
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure appropriate documentation of an advanced directive for one resident (#18), in the selected sample of twenty two (22) residents. Findings include: Record review revealed Resident #18 was admitted to the facility on 07/03/13 with a diagnosis to include Dementia, Diabetes, Hyperlipidemia, Hypothyroidism, and Depression. A review of Resident #18's Advance Directive	F 242	1. A DNR label was placed on the front cover of Resident #18's chart on 7/31/2013 by the charge nurse on duty to indicate the resident's DNR status. 2. A complete chart audit of all residents was conducted 8/16/13 by the DON and ADON to identify residents who have advanced directives in order to determine if DNR labels were appropriately placed. All current residents have DNR labels placed on their charts as indicated. No other residents were identified as being effected. 3. The DON and ADON reviewed with all licensed nurses the process of placing DNR stickers on inside cover of chart, to denote advanced directive status; completed on 8/22/2013. 4. Effective 8/19/13, a 100% chart audit of advanced directives on all newly admitted residents will be the responsibility of the ADON to complete within 24 hours of admission. ADON was educated	8/23/13

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jacqueline H. Woodward</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/14/13</i>
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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 242	Continued From page 1 revealed the resident elected to have "No Cardiopulmonary Resuscitation" (Do Not Resuscitate (DNR)). Further record review revealed there was no evidence the chart was labeled to indicated the resident was DNR. Interview on 07/31/13 at 1:15 PM with Registered Nurse (RN) #1 revealed the facility's process of implementing DNR status was to label the resident's medical record by placing an orange sticker on the nurse aide care plan. She stated, "It is the responsibility of the admitting nurse to do this because without this the resident would be considered a full code!"	F 242	on the audit process by DON on 8/19/13. Effective 8/19/2013, a random selection of 10 charts will be reviewed monthly by the ADON to ensure ongoing compliance and to ensure all charts are reviewed over a 12 month period. Written documentation of the results will be submitted to the DON monthly. 5. All corrective action completed on 8/22/2013.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	1. A care plan was developed by the MDS Coordinator on 7/31/2013, to address the DNR status of Resident #18. The charge nurse on duty 7/31/2013 also placed the DNR information on the daily care plan which is utilized by the certified nurse aides. 2. A 100% audit of all care plans was completed on 8/19/2013 by MDS Coordinator to ensure all residents have a care plan to reflect their DNR status as indicated by advanced directives. No other residents were identified as being effected. 3. The DON and ADON reviewed with all licensed nurses that it is the responsibility of the admitting nurse to complete the interim care plan reflecting the resident's advanced directive/code status upon admission; was completed 8/22/2013. 4. Effective 8/19/2013, a 100% chart audit of care plans related to DNR status on all newly admitted residents will be the	8/23/13

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F 279	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a care plan was developed related to the code status for one resident (#18), in the selected sample of twenty two (22) residents.</p> <p>Findings include:</p> <p>Review of the facility's policy/procedure, no date revealed a care plan will be initiated on all residents, upon admission to the facility.</p> <p>Record review revealed Resident #18 was admitted to the facility on 07/03/13 with a diagnosis to include Dementia, Diabetes, Hyperlipidemia, Hypothyroidism, and Depression.</p> <p>A review of Resident #18's Advance Directive, dated 07/03/13, revealed the resident elected to have "No Cardiopulmonary Resuscitation" (Do Not Resuscitate (DNR)).</p> <p>A review of the Interim Care Plan, dated 07/03/13, revealed there was no care plan developed to address Resident #18's "Do Not Resuscitate" status.</p> <p>Interview on 07/31/13 at 10:45 AM with Licensed Practical Nurse (LPN) # 2 revealed the Do Not Resuscitate (DNR) status should be identified on the care plan developed for all nursing staff.</p> <p>Interview on 07/31/13 at 1:15 PM with Registered Nurse (RN) #1 revealed a DNR care plan was not implemented for Resident #18. She stated, "it is</p>	F 279	<p>responsibility of the ADON to complete within 24 hours of admission. ADON educated on this responsibility by DON on 8/19/2013. Effective 8/19/2013, a random selection of 10 charts will be reviewed monthly by the ADON to ensure ongoing compliance and to ensure all charts are reviewed within a 12 month period. Written documentation of the monthly results will be submitted to the DON.</p> <p>5. All corrective action completed on 8/22/2013.</p>	

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F 279	Continued From page 3 the admitting nurse responsibility to implement the care plan!"	F 279			
F 281 SS=D	<p>Interview on 07/31/13 at 12:15 PM with the Interim Director of Nursing (DON) revealed the resident's code status should be documented on the nursing assistant care plan.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure an order was obtained for a Do Not Resuscitate (DNR) code status in a timely manner for one resident (#18), in the selected sample of twenty two (22) residents.</p> <p>Findings include: A review of the facility's policy/procedure for Advanced Directives revealed the facility should follow the wishes of the resident as previously defined by the resident while competent through legally recognized advance directives or living will. A review of the physician's orders revealed there was no "Do Not Resuscitate" order written for Resident #18.</p> <p>Interview on 07/31/13 at 1:15 PM with Registered Nurse (RN) #1 revealed she was the admitting</p>	F 281	<p>1. A physician's order was obtained for resident # 18 7/31/2013, by the charge nurse on duty, to reflect the resident's DNR status as indicated by advanced directive.</p> <p>2. A 100% chart audit was conducted on 8/16/13 by the DON and the ADON to determine if a physician orders were in place, when indicated, to reflect DNR status. No other residents were identified as being effected.</p> <p>3. The DON and ADON reviewed with all licensed nurses that it is the admitting nurse's responsibility to secure a physician order for DNR status when indicated by advanced directive. This action was completed on 8/22/2013.</p> <p>4. Effective 8/19/2013, a 100% chart audit, ongoing, of physician orders for DNR status on all newly admitted residents will the responsibility of the ADON to complete within 24 hours of admission. ADON was educated on this responsibility by DON on 8/19/2013.</p>	8/23/13	

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F 281	Continued From page 4 nurse for Resident #18. She stated, "normally I write the physician order. It would have been my responsibility to do this on admission, I don't know what happened. Without that physician order written, Resident #18 would be a full code!" Interview on 07/31/13 at 10:45 AM with Licensed Practical Nurse (LPN) #2 revealed the facility's procedure for DNR residents was to have a physician's order. LPN #2 stated, "We are given a list daily of all residents that are a full code and we put that list on our identification badge!" Interview on 07/31/13 at 12:15 PM with the Interim Director of Nursing (DON) revealed "the facility's process was for Social Services to talk with the resident and/or their family upon admission to ask of desired code status. The admission registered nurse and the unit clerk will compile the information as to where the information is to go. I expect the social worker to relay the DNR information to the registered nurse. It would be up to the nursing staff to obtain the DNR order."	F 281	Effective 8/19/2013, a random selection of 10 charts will be reviewed monthly by the ADON to ensure ongoing compliance and ensuring all charts are reviewed within a 12 month period. Written documentation of the monthly results will be submitted to the DON. 5. All corrective action completed on 8/22/2013.		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of 5% or greater	F 332	1. Resident #11 and Resident #24 were observed by charge nurse and ADON on 7/30/2013 immediately and throughout the remainder of the shift, with no adverse effects noted. LPN #1 was counseled on 8/19/2013, by ADON, and appropriate teaching provided on medication administration policy/procedure.	8/23/13	

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F 332	<p>Continued From page 5 involving one resident (#11) in the selected sample of twenty-two (22) residents, and one resident (#24) not in the selected sample. There were twenty-eight (28) opportunities with two (2) medication errors to equal a 7% medication error rate.</p> <p>Findings include:</p> <p>Review of the Administration of Medication policy/procedure, revised 07/12, revealed medications should be given no more than 60 minutes before or 60 minutes after scheduled times.</p> <p>1. Observation of a medication pass for Resident #11, on 07/30/13 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #1 administered Metformin Hydrochloride (HCL) 1000 milligrams (mg) to Resident #11 at this time.</p> <p>Review of the Physician's Order, dated 07/29/13, revealed an order for Metformin 1000 mg twice daily. Review of the Medication Administration Record (MAR), dated July 2013, revealed to administer the Metformin 1000 mg at 8:00 AM and 5:00 PM.</p> <p>2. Observation of a medication pass for Resident #24, on 07/30/13 at 9:20 AM, revealed LPN #1 administered Metformin HCL 500 mg to Resident #24 at this time.</p> <p>Review of the Physician's Orders and MAR, dated July 2013, revealed an order for Metformin HCL 500 mg at 8:00 AM and 1000 mg at 5:00 PM for the diagnosis of Diabetes Mellitus.</p> <p>Interview with LPN #1, on 07/30/13 at 11:50 AM,</p>	F 332	<p>2. All residents who received medication on 7/30/2013 were identified by the charge nurse and ADON and no other residents were determined to be affected.</p> <p>3. The DON and ADON distributed and reviewed the medication administration policy/procedure with licensed nurses and CMTs; which was completed on 8/22/2013.</p> <p>4. Effective 8/19/2013, any nurse who identifies a variance from the medication administration policy will report it to the DON or ADON and a medication error report will be initiated. DON or ADON reviewed this policy/ procedure with all nurses. This action was completed on 8/22/2013. The ADON will complete observations of the medication pass on a random basis of six staff members monthly to monitor and ensure that staff is complying with the Five Rights of Medication Administration (Right Resident, Right Medication, Right Time, Right Dose, Right Route). The ADON will submit written documentation of the monthly results to the DON. Rates and variances will be monitored ongoing by the Performance Improvement Committee for necessary remedies to ensure a medication error rate of less than 5% is maintained.</p> <p>5. All corrective action completed on 8/22/2013.</p>	

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F 332	Continued From page 6 revealed medications should be given one hour before or after the scheduled dose. She verified the Metformin dose for Resident #11 and #24 were both given out of compliance during the observation of medication pass, on 07/30/13. Interview with the Interim Director of Nursing (DON), on 07/31/13 at 11:05 AM, revealed the goal was to administer medications one hour before or after the scheduled time.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to serve food under sanitary conditions related to wearing hair nets appropriately. Findings Include: Review of the Uniform Dress Code policy/procedure, last revised 03/11, revealed staff would wear the approved hair restraint when on duty.	F 371	1. Residents from the dining room were monitored and exhibited no ill effects. Dietary Aide #1 and #2 were counseled on 7/30/13 at 1145 regarding the inappropriate use of their hair net while serving food. 2. All other residents not dining in the dining room were also monitored and exhibited no ill effects. 3. Departmental Policy #E004 was updated on 7/30/13 at 1200 by the Director of Food Services to include specific language emphasizing all hair must be covered with the hair net. The Director of Food Services completed an Educational In- Service on Departmental Policy #E004 with all Dietary Staff on 8/19/13. 4. The Director of Food Services will conduct weekly Hair Net Usage audits effective 8/19/13 by secret surveillance for 6 months to ensure ongoing compliance. Audit reports will be submitted to the administrator weekly.	8/20/13

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F 371	<p>Continued From page 7</p> <p>Observation, on 07/30/13 at 11:30 AM, revealed Dietary Aide #1 and #2 were serving food from the steam table, located in the dining room; however, their hair nets did not completely cover their hair. Dietary Aide #1 had strands of hair exposed from the hair net on the sides, back end front of her head. Dietary Aide #2 also had strands of hair exposed from the back and sides of her head.</p> <p>Interview with the Director/Executive Chef and the Administrator, on 07/30/13 at 11:35 AM and on 07/31/13 at 11:30 AM, respectively, revealed they expected staff to completely cover their hair with the hair nets while serving food.</p>	F 371	5. Corrective action completed on 8/19/2013.	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to</p>	F 441	<p>1. Resident #8 was monitored by ADON on 7/30/2013 at 1515 and exhibited no ill effects. SRNA # 2 was counseled on 7/30/2013 at 1530 by ADON regarding inappropriate hand hygiene. It was determined that SRNA #2 completed a Hand Hygiene Review regarding policy and procedure guidelines of hand hygiene on 6/26/2013. SRNA #2 was checked off on proper linen procedures during initial orientation on 12/16/2012. SRNA# 2 was assigned computer based learning module regarding hand hygiene that was completed on 08/08/2013. Effective 8/22/2013, focused monitoring will be conducted weekly for SRNA# 2 for the next 6 months by the ADON to ensure compliance. Written documentation of the findings will be submitted to the DON monthly.</p>	8/23/13

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F 441	<p>Continued From page 8</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate handwashing and glove changes during incontinent care. Additionally, the facility failed to ensure personnel transported linens so as to prevent the spread of infection.</p> <p>Findings include:</p> <p>Review of the Hand Hygiene policy/procedure, last reviewed 04/13, revealed hands should be washed with soap and water, or cleansed with a waterless, alcohol based product before and after patient contact, upon entering and exiting patient's room, and after gloves were removed.</p> <p>Review of the Linen Handling policy/procedure, last revised 12/11, revealed the handling, storing,</p>	F 441	<p>ADON educated on this process 8/19/2013 by DON.</p> <p>2. All residents identified as having the potential to be affected were assessed by charge nurse and ADON on 7/30/13 at 1600, with no residents exhibiting ill effects. No other residents were identified as being affected.</p> <p>3. All direct care staff completed education on infection control policy/procedures, including hand washing and proper handling of soiled linen at the Annual Safety Fair on 8/21/2013, which included a poster presentation and return demonstration of competency. Those staff members on leave at the time of the fair will be trained prior to the start of their next scheduled shift. On June 1, 2013, all employees were assigned a mandatory annual computer based learning module on infection control, including hand washing and proper handling of soiled linen; completed on 8/22/2013.</p> <p>4. Effective 8/19/2013, the ADON will conduct a minimum of 20 weekly hand hygiene audits by secret surveillance to ensure all employees are monitored over a 6 month period. The ADON will provide written documentation of the weekly results to the DON for review and the ADON will report results monthly to the Infection Prevention Team to track/trend for compliance and performance improvement for a period of 6 months.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2013
NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42184		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 9</p> <p>and transportation of linens would be practiced in a manner to prevent the spread of germs.</p> <p>Observation, on 07/30/13 at 2:45 PM, revealed State Registered Nurse Aide (SRNA) #2 provided incontinent care to Resident #8, then used soiled gloves to put a clean brief on and reposition the resident in bed. SRNA #2 removed one of the soiled gloves. She held a bag of soiled items and a washcloth with visible feces in the hand wearing the soiled glove. She washed the ungloved hand in the sink, then left the room carrying the bag with soiled items and the soiled washcloth down the hallway.</p> <p>Interview with SRNA #2, on 07/30/13 at 3:00 PM, revealed she should have removed both gloves and washed her hands after they were soiled during incontinent care. She revealed she should have placed the washcloth soiled with feces in a bag and washed both hands before leaving the resident's room.</p> <p>Interview with the interim Director of Nursing (DON), on 07/31/13 at 11:50 AM, revealed she expected staff to remove their gloves and wash their hands after incontinent care and before leaving a resident's room. She revealed staff should utilize the "blue bags" in the resident rooms to transport soiled linen.</p>	F 441	<p>ADON was educated on this process 8/19/2013 by the DON.</p> <p>5. All corrective action completed 8/22/2013.</p>		

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NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A Plan of Correction desk review was conducted from the standard Life Safety Code survey conducted on 07/30/13. Cal Turner Rehab and Speciality Clinic was found to be in compliance with the requirements for participation in Medicare and Medicaid.</p>	{K 000}			

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

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164	
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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: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/30/13. Cal Turner Rehab and Specialty Care was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred ten (110) beds with a census of one-hundred six (106) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>This plan of correction is offered as an attempt to provide the highest level of quality services possible to our residents and is not an admission that the deficiencies cited are correct.</p>	



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

Jacqueline H. Woodland

TITLE

Administrator

(X8) DATE

9/9/13

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.

Correction

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NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164	
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K 000	Continued From page 1	K 000	The facility ensures that all smoke barriers are in accordance with NFPA 101 standards.	
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred six (106) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 07/30/13 at 10:50 AM, with the Facility Manager and the Corporate Director revealed the smoke barrier extending above the ceiling located above room #B-19 was penetrated</p>	K 025	<p>1. On 07/30/13 at 10:50 a.m., the Facility Manager identified the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred six (106) residents on the day of survey. On the day of the survey in buildings B and C, penetrations of the smoke barriers were noted respectively above room B19 and the cross corridor doors by the ADON office. The Facility Manager assigned work orders on 7/30/13 to Engineering staff for repairs to the smoke barrier penetrations. Both wall penetrations were sealed by engineering staff by 11:30 a.m. on 7/30/13.</p> <p>2. On 07/30/13, all other smoke and fire barriers were inspected by engineering staff and Facility Manager to ensure all corrective actions were taken. All inspections were completed by 5:00 p.m. on 07/30/13. All residents were identified as having potential to be affected by any smoke or fire barrier penetrations.</p> <p>3. Starting 8/23/13, ongoing smoke and fire barrier zone inspections will be done monthly by engineering staff to ensure 100% of the smoke and fire barriers are</p>	8/1/13

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NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 466 BURNLEY RD. SCOTTSVILLE, KY 42164	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 2 by a wire. Further observation revealed the smoke barrier extending above the ceiling located above the cross corridor doors in building C, by the ADON Office, had a one (1) inch penetration that was not sealed. Interview, on 07/30/13 at 10:50 AM, with the Facility Manager and the Corporate Director revealed they were not aware of the penetrations. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	inspected within a 6 month period. The Facility Manager will make monthly smoke and fire barrier zone assignments to the engineering staff and monitor to ensure 100% of zone inspection completion within 6 months. 4. Starting 8/23/13, the Facility Manager will make monthly assignments to the engineering staff for inspections of smoke and fire barrier zones to ensure 100% completion for all zones within 6 months. Starting 08/23/13, the Corporate Environment of Care Program Manager will assign ongoing quarterly preventive maintenance work orders for the Facility Manager and a second manager from the corporate facility team to inspect all smoke and fire barriers. Starting 08/23/13, all inspections will be reported by the Facility Manager to the Sub-Safety Committee every two months for ongoing monitoring. 5. All corrective actions were completed by 5:00 p.m. on 7/30/13.	
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147 SS=D	Continued From page 3 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred six (106) on the day of the survey. The facility failed to maintain proper use of power strips and covers. The findings include: Observations, on 07/30/13 between 10:30 AM and 1:00 PM, with the Facility Manager and the Corporate Director revealed; 1) Two (2) open electrical junction boxes located above the ceiling above room #B-19. 2) One (1) open electrical junction box located above room #C-18. 3) A refrigerator was plugged into a power strip located in the Administrators Office. Interview, on 07/30/13 between 10:30 AM and 1:00 PM, with the Facility Manager and the Corporate Director revealed they were not aware of the misuse of the power strip, or the open junction boxes.	K 147	The facility ensures that all wiring and equipment are in accordance with NFPA 70, NEC 9.1.2. 1. The Facility Manager assigned work orders on 07/30/13 to Engineering staff to install cover plates for both buildings and remove the refrigerator and power strip from the Administrator's office. All corrective actions were completed by 2:00 p.m. on 07/30/13. 2. On 7/30/13, the Facility Manager and Engineering staff inspected all smoke compartments for the potential to affect residents, staff, and visitors. On 07/30/13, Engineering staff was assigned to look and ensure all electrical junction boxes had cover plates on them. The Engineering staff was also assigned to inspect all refrigerators to ensure they were not plugged into power strips. All inspections were completed by 5:00 p.m. on 07/30/13. No other residents were identified as having the potential to be affected. 3. Starting 08/23/13, the Facility Manager will conduct ongoing monthly Life Safety walk through inspections with the DON that will include, but is not limited to, electrical safety checks. Starting 08/23/13, the Facility Manager will also conduct quarterly Life Safety inspections with another manager from our Facility Management team.	8/1/13

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K 147	Continued From page 4 Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Reference: NFPA 70 (1999 edition)	K 147	4. Starting 08/23/13, the Facility Manager will monitor: • monthly completion of preventive maintenance room inspections including electrical equipment inspections • completion of all work orders for electrical equipment. The Facility Manger will report this information to the Safety Sub Committee every two months. 5. All corrective actions were completed by 5:00 p.m. on 07/30/13	

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NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 466 BURNLEY RD. SCOTTSDALE, KY 42184		
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K 147	Continued From page 5 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147			