STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X4) ID

PREFIX

TAG

F 000

F 157

SS=G

PRINTED: 06/28/2013 **FORM APPROVED** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 06/14/2013 185224 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 20 1561 NEWTON AVE. BOWLING GREEN NURSING AND REHABILITATION CENTER õ BOWLING GREEN, KY 42104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY INITIAL COMMENTS F 000 A recertification survey was conducted on 06/12/13 through 06/14/13 to determine the Submission of this plan of correction is facility's compliance with Federal requirements. not a legal admission that a deficiency The facility failed to meet minimum requirements exists or that this statement of deficiency for recertification with the highest scope and was correctly cited, and is also not to be severity of a "G". construed as an admission of interest 483.10(b)(11) NOTIFY OF CHANGES F 157 against the facility, the Administrator or (INJURY/DECLINE/ROOM, ETC) any employees, agents, or other individuals who draft or may be discussed A facility must immediately inform the resident; in this response and plan of correction. In consult with the resident's physician; and if addition, preparation of this plan of known, notify the resident's legal representative correction does not constitute an or an interested family member when there is an admission or agreement of any kind by accident involving the resident which results in the facility of the truth of any facts Injury and has the potential for requiring physician alleged or see the correctness of any intervention; a significant change in the resident's allegation by the survey agency. physical, mental, or psychosocial status (i.e., a Accordingly, the facility has prepared and deterioration in health, mental, or psychosocial submitted this plan of correction prior to status in either life threatening conditions or the resolution of any appeal which may be clinical complications); a need to alter treatment filed solely because of the requirements significantly (i.e., a need to discontinue an under state and federal law that mandate existing form of treatment due to adverse submission of a plan of correction within consequences, or to commence a new form of ten (10) days of the survey as a condition treatment); or a decision to transfer or discharge to participate in Title18, and Title 19 the resident from the facility as specified in programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as The facility must also promptly notify the resident an agreement with the allegations of

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.

The facility must record and periodically update

TITLE

noncompliance or admissions by the

facility. This plan of correction constitutes

a written allegation of submission of

substantial compliance with Federal

Medicare Requirements.

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,

JER REPRESENTATIVE'S SIGNATURE

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LABORATORY DIRECTOR'S OR PROVIDER/SUPP

§483.12(a).

Facility ID: 100409

		MEDICAID SERVICES				1	<u>). 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 • •			(X3) DATE SURVEY COMPLETED	
		185224	B. WNG			06	/14/2013
NAME OF PR	ROMDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
BOWLING	GREEN NURSING AND	REHABILITATION CENTER		1	561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) Completion Date
	Iegal representative of This REQUIREMENT by: Based on observation and review of the facility consult with the resided alter treatment for one of fourteen (14) resided facility failed to notify pain during treatments change, on 06/12/13 at 10:00 AM, Residen verbal/non-verbal sign nurse continued the tr intervention. On 06/12 #1 winced with pain w his/her face as the nur old dressing to the righ Additionally, on 06/13, #1 began complaining assessed the resident area to the left heel wi area to the left second	is not met as evidenced n, interview, record review, lity's policy/procedure, it was r falled to immediately ent's physician a need to a resident (#1) in the sample ents (Resident #1). The the physician of unrelieved s. During a dressing at 1:15 PM, and on 06/13/13 t #1 exhibited is of pain; however, the eatment without further 2/13 at 1:15 PM, Resident hile tears rolled down rese attempted to remove an ht leg. 13 at 10:15 AM, Resident of left heel pain. The nurse as having a "red, mushy" th a darkened scabbed I toe; however, the nurse sician of the pain to the left	F	157	F157 - Notify of Changes	e 3 3 in f il 3	7/28/13
	Condition policy/proce clinicians would imme	tion of Resident Change in dure, undated, revealed diately consult with the hen there was a significant			pain will be reviewed with the physician for further intervention and a follow up pain assessment completed.		

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Facility ID: 100409

If continuation sheet Page 2 of 26

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185224	B, WING			06/14/2013	
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROWLING		REHABILITATION CENTER			1561 NEWTON AVE.		
BOWLING	OREEN NURSING AND	REMABLE TATION GENTER		1	BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAĞ		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 157	change in the residen psychosocial status. Review of the Pain M. 03/11, revealed the pl notified when pain lev levels for each individ be relieved or interfer or functional ability. Review of the Skin Sy revised 08/08, reveale would be notified of at condition. Record review reveale Resident #1 on 03/20, included Anxiety Diso Disease, Chronic Ulce Arthritis, Pain in Joint, Review of the significa Set, dated 05/20/13, revea resident at high risk fo of the Comprehensive dated 03/20/13, revea having frequent pain, night and limiting day- assessment indicated medication/treatments his/her pain. The resid was a "4" (four) on the	t's physical, mental, or anagement Process, dated hysician and family would be els were outside normal ual resident and could not ed with the resident's goal astem policy/procedure, ed the physician and family hy changes of skin ed the facility admitted (13, with diagnoses which rder, Peripheral Vascular er of the Leg, Rheumatoid and Muscle Weakness, ant change Minimum Data evealed the facility identified ately cognitively impaired, re Ulcer Risk Assessment, led the facility identified the r pressure ulcers. Review Pain Assessment Form, led the resident indicated making it hard to sleep at to-day activities. The pain the resident's moderately relieved lent's pain intensity goal	F	157	 All Licensed staff will be re- educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultan on completion of comprehensive pain assessment, physician notification of unrelieved pain outside the resident's goal for pain levels or pain at unacceptable levels. All Licensed staff will be re-educated by the Director of Nursing, Assistant Director of Nursing Unit Manager or Regional Nurse Consultant on identification of skin impairments, notification of the physician and appropriate treatment. Both of these re-education will be completed by 7/28/13 with no Licensed Staff working after 7/28/13 without having received these trainings. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) resident records pe week for twelve (12) weeks to identify any unacceptable levels of pain to assure that the physician has been notified. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe five (5) wound dressings per week for twelve (12) weeks to assure that the resident does not experience pain levels during treatment at unacceptable levels and if the resident does, the nurse will notify the physician of unacceptable pain levels. The Director of Nursing, Assistant Director of Nursing or Unit Manager 	, , r	
	Plan, dated 05/20/13,	revealed to report			will complete a look behind skin assessment five (5) times per week for		
	unrelieved or unaccep	table levels of pain to the				ļ	

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Facility (D: 100409

If continuation sheet Page 3 of 26

CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	B. WNG		06/14/2013
NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND	***********************************	1 E	REET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104 PROVIDER'S PLAN OF CORREC	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CRÓSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
1:15 PM, with Register a moderate amount of the right leg wound dr of the dressing, the re wincing in pain with fa dressing appeared to leg and difficult to rem cry, with visible tears of face, as RN #1 continn RN #1 indicated the re "pre-medicated" and c removal without any of Observation of a dress 10:00 AM, revealed of from four (4) wounds of Resident #1 continuous treatment, dressing ch Further observation re facial grimacing and c treatment. The resider side while continuous! Observation revealed from three (3) wounds During treatment of the grimacing was observ." "Oh, please." Through wounds, RN #1 stated helping?" and "We are you, isn't it?"	sing change, on 06/12/13 at ered Nurse #1 (RN) revealed f yellow/bloody drainage to essing. During the removal sident was observed icial grimacing. The be stuck to the resident's rove. The resident began to rolling down the resident's used to remove the dressing. esident had been continued the dressing ther intervention. sing change, on 06/13/13 at id dressings were removed on the resident's right side. usly stated "Oh" during the hange of the wounds. evealed the resident with complaints of pain during the nation of the other y stating "Oh God, please." dressings were removed on the resident's left side. ese wounds, facial ed with the resident stating out the treatment of the	F 157	twelve (12) weeks. A look behind assessment is a skin assessment completed after the direct care nur completed a skin assessment to ass that the nurse has identified any ne skin impairments and notified the physician of any new skin impairm The results of these audits will be reviewed with the Quality Assuran Committee Monthly for at least the (3) months to assure ongoing compliance. If at any time concern identified, a Quality Assurance Committee will convene to review make further recommendations as needed. The Quality Assurance Committee will consist of at a min the Administrator, Director of Nur Assistant Director of Nursing, Soc Services Director with the Medical Director attending at least quarterly	se has sure ew nents. nee ree and imum sing, ial
and "mushy." She stat	ed "We need to prop that			

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 100409

If continuation sheet Page 4 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	A. BUILD	NG		i co	ATE SURVEY DMPLETED
OVIDER OR SUPPLIER	REHABILITATION CENTER		1561	NEWTON AVE.	<u> </u>	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
heel up." RN #1 add darkened scabbed ard PM, revealed the pain effective during treatm rate of pain during the an "8" eight out of "10 indicated that was "pr Observation of Reside AM, revealed a red, n left heel per assessme of Nursing (ADON). S "boggy" underneath. a blister had ruptured drainage noted. Addit	itionally observed a ea to the left second toe. Int #1, on 06/13/13 at 5:30 medications were not tents. He/she revealed the treatment on 06/13/13 was 0" (ten). The resident etty bad" pain. ent #1, on 06/14/13 at 10:45 on-blanchable area to the ent of the Assistant Director She indicated the area was At approximately 10:55 AM, on the left heel with serous ionally, an unstageable	F	157			
documentation related toe. Further review re	to the left heel/left second vealed no documented					
revealed she had not physician of unrelieve Resident #1 always ha She stated the resider before it even started, had anxiety disorder, v problem." When a res before touching them, anxiety. She revealed management was effe	notified the resident's d pain. She indicated ad pain during treatments. In feared the treatment RN #1 stated the resident which was "a lot of the ident complained of pain it had to be determined the resident's pain ctive for him/her as the					
	CORRECTION OVIDER OR SUPPLIER GREEN NURSING AND SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From page heel up." RN #1 add darkened scabbed ard Interview with Resider PM, revealed the pain effective during treatm rate of pain during the an "8" eight out of "10 indicated that was "pr Observation of Reside AM, revealed a red, n left heel per assessme of Nursing (ADON). S "boggy" underneath a blister had ruptured drainage noted. Addii area to the left second centimeters (cm) Record review, on 06/ documentation related toe. Further review re- evidence new orders v Interview with RN #1, revealed she had not u physician of unreliever Resident #1 always has She stated the resider before it even started. had anxiety disorder, v problem." When a res- before.touching-them, anxiety. She revealed management was effe	CORRECTION IDENTIFICATION NUMBER: 185224 OVIDER OR SUPPLIER GREEN NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 heel up," RN #1 additionally observed a darkened scabbed area to the left second toe. Interview with Resident #1, on 06/13/13 at 5:30 PM, revealed the pain medications were not effective during treatments. He/she revealed the rate of pain during the treatment on 06/13/13 was an "8" eight out of "10" (ten). The resident indicated that was "pretty bad" pain. Observation of Resident #1, on 06/14/13 at 10:45 AM, revealed a red, non-blanchable area to the left heel per assessment of the Assistant Director of Nursing (ADON). She indicated the area was "boggy" underneath. At approximately 10:55 AM, a blister had ruptured on the left heel with serous drainage noted. Additionally, an unstageable area to the left second toe measured 1 x 1.4 centimeters (cm). Record review, on 06/14/13, revealed no documentation related to the left heel/left second toe. Further review revealed no documented evidence new orders were initiated. Interview with RN #1, on 06/14/13 at 10:10 AM, revealed she had not notified the resident's physician of unrelieved pain. She indicated Resident #1 always had pain during treatments, She stated the resident feared the treatment before it even started, RN #1 stated the resident had anxiety disorder, which was "a lot of the problem." When a resident complained of pain before-touching-them, it-had-tob be determined	CORRECTION IDENTIFICATION NUMBER: A. BUILDI 185224 B. WING. OVIDER OR SUPPLIER B. WING. GREEN NURSING AND REHABILITATION CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREETI- TAG Continued From page 4 F heel up." RN #1 additionally observed a darkened scabbed area to the left second toe. Interview with Resident #1, on 06/13/13 at 5:30 PM, revealed the pain medications were not effective during treatments. He/she revealed the rate of pain during the treatment on 06/13/13 was an "6" eight out of "10" (ten). The resident indicated that was "pretty bad" pain. Observation of Resident #1, on 06/14/13 at 10:45 AM, revealed a red, non-blanchable area to the left heel per assessment of the Assistant Director of Nursing (ADON). She indicated the area was "boggy" underneath. At approximately 10:55 AM, a bilster had ruptured on the left heel with serous drainage noted. Additionally, an unstageable area to the left second toe measured 1 x 1.4 centimeters (cm). Record review, on 06/14/13, revealed no documentation related to the left heel/left second toe. Further review revealed no documented evidence new orders were initiated. Interview with RN #1, on 06/14/13 at 10:10 AM, revealed she had not notified the resident's physician of unrelieved pain. She indicated Resident #1 always had pain during treatments. She stated the resident feared the treatment before i even started. RN #1 stated the resident had anxiety disorder, which was "	CORRECTION IDENTIFICATION NUMBER: A BUILDING 185224 B. WING OVIDER OR SUPPLIER STREET GREEN NURSING AND REHABILITATION CENTER BOW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX Continued From page 4 F 157 heel up." RN #1 additionally observed a darkened scabbed area to the left second toe. Interview with Resident #1, on 06/13/13 at 5:30 PM, revealed the pain medications were not effective during treatments. He/she revealed the rate of pain during the treatment on 06/13/13 was an "8" eight out of "10" (ten). The resident indicated that was "pretty bad" pain. Observation of Resident #1, on 06/14/13 at 10:45 AM, revealed a red, non-blanchable area to the left heel per assessment of the Assistant Director of Nursing (ADON). She indicated the area was "boggy" underneath. At approximately 10:55 AM, a blister had ruptured on the left heel/left second toe. Further review revealed no doccumentation related to the left heel/left second toe. Further review revealed no documented evidence new orders were initiated. Interview with RN #1, on 06/14/13, at 10:10 AM, revealed she had not notified the resident's physician of unrelieved pain. She indicated Resident #1 always had pain during treatments. She stated the resident fleated the treatment before it even started. RN #1 stated the resident had anxiety disorder, which was "a tot of the problem." When a resident complained of pain before. Towning the revealed the resident had anxiety disorder, which was "a tot of the	CORRECTION IDENTIFICATION NUMBER: A BUILDING 185224 B. WING OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GREEN NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE Ideation Ideation Igan PROVERTS PLAN DE CORRECTED BY FULL Igan Ideation Ideation Ideation Interview with Resident #1, on 06/13/13 at 5:30 PM, revealed the pain medications were not effective during treatments. Heishe revealed the rate of pain during the treatment on 06/13/13 was an "6" eight out of "10" (ten). The resident indicated that was "pretty bad" pain. Observation of Resident #1, on 06/14/13 at 10:455 AM, revealed a red, non-blanchable area to the left heel pare assessment of the Assistant Director of Nursing (ADON). She indicated the area was "boggy" underneath. At approximately 10:55 AM, a bilster had ruptured on the left heel with secous drainage noted. Additionally, an unstageable area to the left second toe measured 1 x 1.4 centimeters (cm). Record review, on 06/14/13, revealed no documentation related to the oldine the resident indicated that resident frage physician of luncilleed than ecsident before towen started. RN #1 stated the resident before towen started. IN #1 stated the resident anxiety.	CORRECTION IDENTIFICATION NUMBER: A BURLIDING A BURLIDING CC 040DER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 1051 NEWTON AVE STREET ADDRESS, CITY, STATE, ZIP CODE 0500000000000000000000000000000000000

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185224	8. WNG	**************************************	06/14/2013
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	1	EET ADDRESS, CITY, STATE, ZIP CODE 561 NEWTON AVE. OWLING GREEN, KY 42104	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OEFICIENCY)	I SHOULD BE COMPLETION
F 157	Continued From page	• 5	F 157		
in a second s	10:10 AM, revealed si "mushy" area to the re assessment, on 06/13 resident's pain to the li it was significant. She notified of the area; he ADON, on 06/14/13 a no knowledge of the a with the state surveyo #1 revealed she did n second toe; however, ADON aware. She sta whose responsibility if of the new areas. She her responsibility since the responsibility since 06/14/13 at 4:45 PM, to try other measures and call the physician An attempted interview primary physician, on revealed he was not a Interview with the ADC AM, revealed if a new would be the nurse's r physician. Interview with the DON revealed she expected document, and notify t areas identified.	v with Resident #1's 06/14/13 at 10:35 AM,			

FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 6 of 26

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO) <u>. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETEO	
		185224	B. WING			06/	14/2013
	OVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1661 NEWTON AVE. BOWLING GREEN, KY 42104		661 NEWTON AVE.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) Completion Date
	notify the physician of a resident. Continued Director, revealed he the physician if pain m during a treatment. 483.15(h)(1)	he would expect staff to any new areas identified on i interview with the Medical would expect staff to notify nedication was not effective		157 252			
SS=D	ENVIRONMENT The facility must provi comfortable and home	elike environment, allowing or her personal belongings			 F252 - Safe/Clean/Comfortable/ Homelike Environment 1. The identified resident rooms # 1,2,11 and 34 will have window blinds installed by the Maintenance director 1 7/12/13. 2. The Administrator and Housekeeping supervisor will complet an audit of all resident rooms to assure 	by te	7/28/13
	by: Based on Interview, or review and facility poli facility failed to ensure was comfortable and H absence of window co thirty-four (34) residen The findings include: Observations on 06/12 06/14/13 at 3:45 PM, r rooms (rooms 1, 2, 11 windows had no windo blinds, shades, and/or Interview with Assistar (ADON), on 06/14/13 a window coverings wer	ts' rooms. 2/13 at 6:30 AM and on revealed five residents' and 34) revealed the ow coverings such as curtains. Int Director of Nursing at 3:45 PM, revealed the e a housekeeping and/or			that they have window coverings and present a comfortable home like environment by 7/28/13. Any identifie as not being homelike and comfortable or without window coverings will be made comfortable and homelike or ha window coverings installed by 7/28/13 3. The Administrator will re-educate the Housekeeping Supervisor by 7/28/13 on the requirement of a comfortable home like environment ar window coverings. 4. The Administrator and Housekeeping Supervisor will comple weekly audits of all resident rooms for twelve (12) weeks to assure that all rooms have window coverings and	ed ve 3. 1d	
1	not aware there were i	he ADON stated she was resident rooms without the outside wall windows.			present as comfortable and homelike. The results of these audits will be		

FORM CMS-2567(02-90) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 7 of 26

PRINTED: 06/28/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED 185224 9. WING 06/14/201: 06/14/201: NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1551 NEWTON AVE. 06/14/201: BOWLING GREEN NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1551 NEWTON AVE. 06/14/201: (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX CROSS-REFERENCED TO NUE APPROPRIATE 000000000000000000000000000000000000			MEDICAID SERVICES	- <u> </u>		· · · · · · · · · · · · · · · · · · ·	1	<u>). 0938-039</u>
MAKE OF PROMUDER OR SUPPLIER STREET ADDRESS, CITY, SATE, 2P CODE BOWLING GREEN NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, SATE, 2P CODE BOWLING GREEN NURSING AND REHABILITATION CENTER DOWLING GREEN, WY 4704 PMEX SECHAFGENERVIST OF EXCENTIONS PMEX SECHAFGENERVIST PMEX SECHAFGENERVIST The ADON revealed the absence of window coverings put testidents privage if risk interview with the busekeeping Supervisor in the presence of the Environmental Services FEEL District Manager, on OS/14/13 at 4:50 PM; revealed he/she was not aware there were erelident rooms should be homelike and have curtains or bindis covering an outside window to ensure privace or of arcsing Supervisor stated the resident rooms should be homelike and have curtains or bindis covering an outside window to ensure privacian order stated the facility must meet professional stan			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
BOWLING GREEN NURSING AND REHABILITATION CENTER Isst NEWTON AVE. BOWLING GREEN, KY 42104 COULING GREEN, KY 42104 Difference Action should be reached before action should be approximation. Difference Action should be reached before action should be reached before action should be reached action should be approximation. Difference Action should be reached action should be reached action should be approximation. Difference Action should be reached action should be approximation. F 252 Continued From page 7 The ADON revealed the absence of window coverings put resident's privacy at risk. Interview with Director of Nursing (DON), on 06/F/4/13 at 415 PM, revealed be full and know who was responsible for ensuring the residents' rooms had window coverings, but each window should have something. Interview with the Housekeeping Supervisor in the presence of the Environmental Services District Manager, on 06/F/4/13 at 450 PM; revealed hefbs was not aware there were resident rooms without blinds, curtains, or shades. The Housekeeping Supervisor stated the resident rooms without blinds, curtains, or shades. The Housekeeping Supervisor stated the resident rooms without blinds, curtains, or shades. The three resident. F 281 F 281 Services Provided Meet Professional Standards 7/28/1 F 281 433.20(k)(3)(3) SERVICES PROVIDED MEET SS=D F 281 1. The dressings for resident # 1 were noted to be changed op rphysician orders by the Director of Nursing or Unit Manager by 7/28/13 to assure all physician orders have been followed by the Director of Nursing or Unit Manager by 7/28/13 to assure all physician orders have been followed or the physician another shave been followed or the physician another shave been followed in the falled to follow physician's orders related to			185224	B, WING		······································	06	14/2013
BOWLING GREEN NURS GRADE REHAULTRATOR CENTER DOWLING GREEN, KY 42104 PAYID PREFX TRO SUMMARY STATEMENT OF DEFICIENCIES RECOUNTORY ORUSE DEPARTORY RECOUNTORY ORUSE DEPARTORY RECOUNTORY ORUSE DEPARTORY TRO D PROVIDERS YEAL NOT CORRECTION (REACTORY ORUSE DEPARTORY (REACTORY ORUSE DEPARTORY (RE	NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
Down in Summary Statistication of DEFICIENCIES PERCENCY Discretion	BOWLING	GREEN NURSING AND	REHABILITATION CENTER		1	561 NEWTON AVE.		
Prefrx Txo IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTRY/NO INFORMATION Txo PRECE Txo Construction (CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Construction (CROSS-REFERENCE TO THE APPROPRIATE (CROSS-REFERENCE TO THE APPROPRIATE (CROSS-REFERENCE TO TO THE APPROPRIATE (CROSS-REFICANCE TO TO THE APPROPRIATE (CROSS-REFERENCE TO TO THE					В	OWLING GREEN, KY 42104		
 F 282 Continued Prom page 7 Committee Manchily for at least three (3) months to assure angoing coverings put resident's privacy at risk. Interview with Director of Nursing (DON), on O6/14/13 at 415 PM, revealed she did not know who was responsible for ensuring the residents' nooms thad window coverings, but each window should have something. Interview with the Housekeeping Supervisor in the presence of the Environmental Services Director with the Medical Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly. F 281 F 281 See PROFESSIONAL STANDARDS This REQUIREMENT is not met as evidenced by: Based on observation, interview, it was determined the facility failed to ensure services provided met professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, it was determined the facility failed to ensure services provided met professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, it was determined the facility failed to follow the residents (Resident #1). The facility failed to follow physician sorters related to a daily dressing change to the residents' right leg. The findings include: F 281 The findings include: F 282 Committee Monthly for at least three (3) months to assure angulate. F 283 Committee Mill const to a montified in a second provisor in the professional standards of quality. F 284 F 285 Committee Millow binds, and the professional standards of quality. F 285 Committee Millow binds, and the professional standards of quality. F 286 The services provided met professional standards of quality. F 287 This REQUIREMENT is not met as evidenced by: Based on observation, interview, it was determined the facility failed to follow physician sorters related to a daily dressing change to the residents' right	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	9E	(XS) COMPLETION DATE
The services provided or arranged by the facility must meet professional standards of quality.2. A review of all current residents' physician orders for the past 30 days will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure all physician orders have been followed or the physician has been notified if unable to follow the order. Any identified as not being followed without physician notification will have physician notification will have physician notification of all wound dressings will be completed by the Director of Nursing, Assistant Director daily dressing change to the resident's right leg.The findings include:2. A review of all current residents' physician orders for the past 30 days will be completed by the Director of Nursing, Assistant Director direction. An observation of all wound dressings will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure treatment were completed per physician orders. Any identified as not	F 281	The ADON revealed in coverings put residen interview with Director 06/14/13 at 4:15 PM, who was responsible rooms had window co should have somethin interview with the Hou the presence of the E District Manager, on 0 revealed he/she was resident rooms without shades. The Houseker resident rooms should curtains or blinds cove ensure privacy for the 483.20(k)(3)(i) SERVI	he absence of window I's privacy at risk. r of Nursing (DON), on revealed she did not know for ensuring the residents' overings, but each window ng. usekeeping Supervisor in nvironmental Services 06/14/13 at 4:50 PM; not aware there were ut blinds, curtains, or seping Supervisor stated the d be homelike and have ering an outside window to resident. CES PROVIDED MEET			Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns ar identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimut the Administrator, Director of Nursing Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly. F281 – Services Provided Meet Professional Standards 1. The dressings for resident # 1 were noted to be changed per physician order	1 Im 5,	7/28/13
physician orders. Any identified as not		must meet profession This REQUIREMENT by: Based on observation review, it was determi ensure services provis standards of quality for (14)sampled residents failed to follow physici	al standards of quality, is not met as evidenced n, interview, and record ned the facility falled to ded met professional r one (1) of fourteen s (Resident #1). The facility an's orders related to a			2. A review of all current residents' physician orders for the past 30 days will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure all physician orders have been followe or the physician has been notified if unable to follow the order. Any identified as not being followed withou physician notification will have physician notification for further direction. An observation of all wound dressings will be completed by the Director of Nursing, Assistant Directo of Nursing or Unit Manager by 7/28/12	d ut d 3	
The result had no should helios teleford to		·	cific policy related to					
The second secon			· · · · · · · · · · · · · · · · · · ·			• • • • • • • • • • • • • • • • • • •		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 8 of 26

PRINTED: 06/28/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION		OATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	S	TREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETIO DATE
F 281	dressing intact to to 06/12/13. There w brownish/pink ting outside of the dress under the resident Interview with the 06/13/13 at 5:30 P was going to chan did not. Observation, on 06 dressing intact to to 06/14/13. Record review rev Resident #1 on 03 included Periphera Chronic Ulcer of th Significant Change dated 05/20/13, re resident as modera required extensive and transfer. Review of the Phys 05/30/13, and the Record (TAR), date order for Solosite H dressing topically, the TAR was receiv 06/13/13 at 5:45 P to complete the tree	n's orders. 6/13/13 at 5:30 PM, revealed a the resident's right leg, dated as a large amount of ed drainage observed on the asing, as well as a towel laying 's leg. Resident #1's husband, on M, revealed the nurse said she ge the dressing; however she 6/14/13 at 8:10 AM, revealed a he resident's right leg, dated ealed the facility admitted /20/13, with diagnoses which al Vascular Disease and le Leg. Review of the e Minimum Data Set (MDS), vealed the facility identified the ately cognitively impaired and assistance with bed mobility sician's Orders, dated Treatment Administration ed June 2013, revealed an Hydrogel Wound (wet-to-dry) daily to the right calf. A copy of ved by the surveyor, on M. The TAR revealed an order atment on dayshift (6:00 rever, it was not initialed as	F 28	 will have MD notification for direction. 3. All Licensed Nurses will educated on following physica and notification of the physica This re-education will be control the Director of Nursing or Unit P and will be completed by 7/2 no licensed nurse working pawithout having received this education. 4. The Director of Nursing or Unit P will audit five (5) resident's precords weekly for twelve (1) assure physician orders have followed or the physician waif unable to follow. In additio Director of Nursing, Assistar of Nursing or Unit Manager five (5) wound treatments pet twelve (12) weeks to assure the treatment was completed per order. The results of these au reviewed with the Quality Assure (3) months to assure ongoing compliance. If at any time content field, a Quality Assurance Committee will convene to remake further recommendation needed. The Quality Assurance Committee will consist of at the Administrator, Director of Nursing Services Director with the Manager of the Administrator, Director of Nursing Services Director of Nursing Services Director of Nursing Services Director of Nursing Services Director with the Manager of Nursing the Administrator, Director of Nursing Services Director of Nursing Services Director with the Manager of Nursing Services Director w	be re- cian orders cian if m orders. npleted by istant Manager (8/13 with ast 7/28/13 re- Assistant Manager medical 2) weeks to been s notified on, the th Director will audit r week for he physician dits will be ssurance ast three ce eview and ns as ce a minimum f Nursing, c, Social edical	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 9 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY
				-			
		185224	B. WNG		and the second secon	0	6/14/2013
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) CÓMPLETION DATE
F 281	Continued From page	9	F	281			
	AM, revealed staff did	nt #1, on 06/14/13 at 9:25 not change the dressing on ged after his/her bath, on					
	(ADON), on 06/14/13 treatment to the reside completed by her, on 6:45 AM. She indicate	06/14/13 at approximately id the dressing had been reatment; therefore, she					
	06/14/13 at 10:10 AM, complete the treatmer 06/13/13. RN #1 reve Dayshift Charge Nurse						
	revealed she was the 06/13/13. She further typically completed tre	on 06/14/13 at 2:40 PM, Dayshift Charge Nurse on stated the Charge Nurse atments; however, she ted the dressing change					
	revealed she was the Resident #1, on 06/13	on 06/14/13 at 9:45 AM, nurse on evening shift for /13. She stated she did not t to the resident's right leg					
		ctor of Nursing (DON), on evealed she expected staff s, per the physician's					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 10 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/28/2013 FORM APPROVED OMB NO: 0938-0391

		MEDICAID SERVICES			OMB NO, 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED
		185224	B. WING	<u>, , , , , , , , , , , , , , , , , , , </u>	06/14/2013
NAME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
BOWLING	GREEN NURSING AND	REHABILITATION CENTER	1	1581 NEWTON AVE.	
			E	BOWLING GREEN, KY 42104	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 281	Continued From page	e 10	F 281		
	orders,				
F 282	483.20(k)(3)(ii) SERV	ICES BY QUALIFIED	F 282		
SS=D	PERSONS/PER CAR			F282 – Services by Qualified	7/28/13
				Persons/Per Care Plan	
		d or arranged by the facility			
	must be provided by			1. The Assistant Director of Nursing	g
		resident's written plan of		observed on 7/5/13 that resident # 1'	s
	care.			care plan interventions were being	
				followed; that staff had documented	
				pain location; rate of pain prior to an	id
				after intervention and the dressing	
	This REQUIREMENT	is not met as evidenced		change was completed without	
	by:			exceeding the resident's stated pain	
	-	n, Interview, record review,		goal. 2. A complete audit of all resident's	
	and review of the faci	lity's policy/procedure, it was		records will be completed by the	
		/ failed to ensure services		Director of Nursing, Assistant Direc	tor
		lified persons in accordance		of Nursing or Unit Manager by 7/28	
		ritten plan of care for one		to assure all care plan interventions a	
		impled residents (Resident		in place. Any intervention not in place	
	#1).			will be implemented.	
	The findings include:			3. All Licensed Nurses will be re-	
	The indings include.			educated by the Director of Nursing,	
	Review of the guidelin	tes for the Resident		Assistant Director of Nursing or Uni	
		Plan, dated 09/08, revealed		Manager on the requirement to follo	W
		hensive Care Plan should	8	the resident's plan of care to include	•
		disciplinary approach to		rating pain before and after treatmen including location of pain, report	L
		nd chronic needs of the		unrelieved pain or unacceptable pain	
	resident living in the fi	acility.		levels to the physician and stop	
	– 4 –			treatment if unacceptable pain	
		ed the facility admitted		implement further intervention befor	e
		/13, with diagnoses which		resuming treatment. This re-education	
	· •	rder, Peripheral Vascular er of the Leg, Rheumatoid		will be completed by 7/28/13.	
		and Muscle Weakness.		4. The Director of Nursing, Assistan	
		ant Change Minimum Data		Director of Nursing or Unit Manager	
1	Transmont of the originate	ant onongo minimum Data	1	will audit five (5) resident's pain flow	v

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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100400

If continuation sheet Page 11 of 26

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PRINTED: 06/28/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
		185224	B. WING			06	/14/2013
	ROVIDER OR SUPPLIER B GREEN NURSING AN	D REHABILITATION CENTER		158	ET ADDRESS, CITY, STATE, ZIP CODE 61 Newton Ave. Dwling Green, ky 42104		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFD TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	identified the reside impaired. Review of Assessment Form, resident indicated h hard to sleep at nigl activities. The pain resident's medicatio relieved his/her pain goal was a "4" (four zero to ten). Review of the Risk f Plan, dated 05/20/1 location and rate of interventions. Repo levels of pain to the Review of the Contr sheet, dated 06/12/ Nurse (RN) #1 admi medication) 4 milligr 7:05 AM, Review of Record (MAR), date revealed the Dilaudi generalized pain; ho pain documented. F revealed the resider 8:00 AM, but no rate Observation, on 06/ Resident #1 was sitt completing physical complained of his/he appeared uncomfort	nt as moderately cognitively f the Comprehensive Pain dated 05/20/13, revealed the aving frequent pain, making it nt and limiting day-to-day assessment indicated the in/treatments moderately n. The resident's pain intensity) on the pain scale of 0-10 (for Alteration in Comfort Care 3, revealed to identify the pain prior to and after any of unrelieved or unacceptable physician as needed. olled Substance Proof of Use 13, revealed Registered inistered Dilaudid (pain fam (mg) to Resident #1 at the Medication Administration d 06/12/13 at 7:05 AM, d was administered for swever, there was no rate of Further review of the MAR at's pain had decreased at of pain was noted. 12/13 at 10:00 AM, revealed ing up in his/her room, after therapy. The resident er "bottom" hurting and	F2		sheets per week for twelve (12) weel to assure pain rate before and after intervention and location of pain are documented, that the physician was notified of any unrelieved or unacceptable levels of pain to the physician. The Director of Nursing, Assistant Director of Nursing or Uni Manager will observe five (5) wound dressing changes per week to assure that the pain Is relieved or at accepta levels or the nurse stops treatment fo further intervention. The results of th audits will be reviewed with the Qua Assurance Committee Monthly for a least three (3) months to assure ongo compliance. If at any time concerns a identified, a Quality Assurance Committee will convene to review at make further recommendations as needed. The Quality Assurance Committee will consist of at a minim the Administrator, Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	t r ese lity t ing tre nd um	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u>10.0938-0391</u>
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON			TE SURVEY MPLETED
	_	185224	8. WNG			0	6/14/2013
NAME OF PR	OVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
DOWUND					EWTON AVE.		
BUNLING	GREEN NURSING AND	REHABILITATION CENTER		BOWI	LING GREEN, KY 42104		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRE	CTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)		COMPLETION DATE
F 282	Continued From page	12	F.	282			
				5V2			
	present. At 10:30 AM, the resident remained in the wheelchair with facial grimacing.						
	Further observation, o	on 06/12/13 at 11:50 AM,		Í			
		remained up in his/her	Î			•	
		vealed his/her "bottom" was					
	still hurting "pretty bac	j.*					
		led Substance Proof of Use					
	sheet, dated 06/12/13						
	of the MAR, dated Jur	4 mg at 12:40 PM. Review					
		location, rate of pain, or					
		edication given at 12:40					
	PM.						
	Interview with RN #1,	on 06/14/13 at 10:10 PM					
	and 3:00 PM, revealed	d she "tried" to look at the					
	care plans as she cha	rted on residents. She was					
		of pain medication included					
		in, and a re-evaluation;					
		sure of the reason it was not					
	resident pain medicati	/13. She did not give the					
	•	, as it was not time for a					
		e physician was not notified					
	of unrelieved pain, per						
	Review of the Impaire	d Skin Integrity Care Plan,					
		led if there was complaints		l			
		ent, stop the treatment,		Ì			
		e, and seek pain relief.					
		e treatment when the pain					
******	was-reported as accept	dable,					
		sing change, on 06/12/13 at					
1	1:15 PM, revealed a m	noderate amount of		1			
i		e to the right leg wound					

FORM CMS-2567(02-09) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 13 of 26

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION		TE SURVEY MPLETED
		185224	B. WING		0	6/14/2013
	OVIDER OR SUPPLIER	ND REHABILITATION CENTER	1561	T'ADDRESS, CITY, STATE, ZIP COL NEWTON AVE. WLING GREEN, KY 42104	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	resident was wincir Further observation appeared to be stud- was difficult to remo- with visible tears ro as RN #1 continued #1 indicated the res "pre-medicated" and dressing without im- intervention. Observation of a dr 10:00 AM, revealed from four (4) wound Further observation continuously stated treatment/dressing revealed facial grim during the treatment the other side while please." Dressings wounds on the reside treatment of these wo observed with the re- stated "Is the pain p almost done. It's ha Interview with RN # and 3:00 PM, reveal pain during treatment him/her as the reside treatments on 06/12 "typical."	e removal of the dressing, the or pain with facial grimacing, or revealed the dressing of the resident's leg and ove. The resident began to cry, lling down the resident's face, d to remove the dressing. RN sident had been d continued removing the oplementing any other essing change, on 06/13/13 at d old dressings were removed ls on the resident's right side. or revealed Resident #1 "Oh" during the of the wounds. Observation hacing and complaints of pain it. The resident was rolled to e continuously stating "Oh God, were removed from three (3) dent's left side. During wounds, facial grimacing was esident stating "Oh, please." atment of the wounds, RN #1 oill not helping?" and "We are	F 282			

PRINTED: 06/28/2013 FORM APPROVED OMB NO: 0938-0391

STATEMENT	DF DEFICIENCIES CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPL A, BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/14/2013	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 282 F 309	interventions on R generic and should individualized; how follow the interven	M, revealed she felt the esident #1's care plan were d have been more vever, she still expected staff to tions.	F 282			
503 SS=G	HIGHEST WELL E Each resident mus provide the necess or maintain the hig mental, and psych	CARE/SERVICES FOR BEING st receive and the facility must sary care and services to attain thest practicable physical, osocial well-being, in the comprehensive assessment	F 309	 F309 – Provide Care/Services for Highest Well Being 1. A comprehensive pain assessment was completed on Resident # 1 on 7/5/13 by the Director of Nursing that indicated her new pain regimen was effective. The Assistant Director of Nursing noted on 7/5/13 during a wound treatment that the resident did not exhibit any signs or symptoms of pain greater than the stated pain goal. The Director of Nursing noted on 	7/28/13	
	by: Based on observa and review of the f determined the fac resident received t services to attain o practicable physica well-being, in acco one (1) of fourteen (Resident #1). On complained of unre after pain medicati	NT is not met as evidenced ation, interview, record review, acility's policy/procedure, it was allity failed to ensure each the necessary care and or maintain the highest al, mental, and psychosocial rdance with the plan of care for (14) sampled residents 06/12/13, Resident #1 elieved pain three (3) hours on was given; however, he/she of further intervention until the		 7/8/13 that staff documented pain before and after as needed pain medication was given on 7/8/13. 2. A comprehensive pain assessment will be completed on all current residents by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure that all residents pain interventions are effective for their goals. Any identified as not being effective will have physician notification with further interventions and reassessment. An 		
	next "as needed" o given. During a wo 1:15 PM, Resident	r further intervention until the lose of medication could be und treatment, on 06/12/13 at #1 was observed wincing in ng down his/her face; however,		observation of all current residents with wound treatment dressing orders will be completed by 7/28/13 by the Director Nursing, Assistant Director of Nursing	be of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 15 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILON		CONSTRUCTION	(X3) DATE COMP	SURVEY
•		185224	B, WING		·····	06/	14/2013
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		15	EET ADDRESS, CITY, STATE, ZIP CODE 581 NEWTON AVE. OWLING GREEN, KY 42104	, * ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFU TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	intervention. Residen and verbal signs of pa treatment, on 06/13/1 nurse continued the tu intervention. Addition assess and documen and after pain medica The findings include: Review of the Pain M policy/procedure, data facility would react to needs based on the re and the resident's goa facility's goal was to e appropriate pain relief the residents' pain dic function within their do functional ability. Doc would be recorded ald pain reduction using a post intensity evaluati documented in a time if the intervention was should be repeated un adequate relieve and/ met. Record review reveale Resident #1 on 03/20/ included Anxiety Disor Disease; Chronic Uice Arthritis, Pain in Joint, Review of the Signific Set, dated 05/20/13, r	he treatment with no further t #1 exhibited non-verbal ain during a wound 3 at 10:00 AM; however, the reatment without further ally, the facility failed to t the resident's pain before ation was administered. anagement Process ed 03/11, revealed the the resident's pain control esident's goals for pain relief als for functional ability. The ensure all residents received f measures to assure that a not affect their ability to	F3	309	or Unit Manager to ensure that all residents with wound treatment interventions are effective. Any noted have pain during treatment not relieve by interventions will have physician notification with further interventions and follow up assessment completed. An audit of all current residents who receive as needed pain medications w be reviewed by the Director of Nursing Assistant Director of Nursing or Unit Manager by 7/28/13 to assure that pai is assessed before and after as needed pain medications are administered. At identified as not having pain rated before and after pain medication administrated will have a pain assessment completed with follow up with the physician for pain levels unrelieved or unacceptable for further intervention and follow up assessmen completed. These audits will be completed by 7/28/13. 3. All Licensed Nurses will be re- educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultar related to pain assessments, pain goal and physician notification related to unacceptable pain levels: stopping treatment with unacceptable levels of pain with further intervention before resuming treatment as well as documentation of pain levels before a after administration of as needed pain medication. This re-education will be completed by 7/28/13. 4. The Director of Nursing, Assistant Director of Nursing, Assistant	ed ill ig, n· ny t s at	

FORM CMS-2567(02-99) Previous Versions Obsolete

Fadlity IO: 100409

If continuation sheet Page 18 of 28

PRINTED: 06/28/2013 FORM APPROVED OMB NO, 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	сом	E SURVEY PLETED
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	and required exte mobility and trans Comprehensive P 05/20/13, revealed frequent pain, ma limiting day-to-day assessment indica medication/treatm his/her pain. The f was a "4" on the p Review of the Phy through 06/30/13, following pain med 1. Fentanyl (contre- microgram (mcg)/ every seventy-two 2. Hydromorphone medication) 4 milli hours, as needed, 3. Acetaminophen tablet every four (a Review of the Rist Plan, dated 05/20, location and rate of interventions. Rep levels of pain to th Review of the Corr sheet, dated 06/12 Nurse (RN) #1 add Resident #1 at 7:0 Medication Admini 06/12/13 at 7:05 A administered for g was no rate of pain	nsive assistance with bed fer. Review of the aan Assessment Form, dated d the resident indicated having king it hard to sleep at night and y activities. The pain ated the resident's nents moderately relieved resident's pain intensity goal aan scale of 0-10. vsician's Orders, dated 06/01/13 revealed an order for the dications: olled pain medication) 100 hour patch, one patch topically o (72) hours e (Dilaudid, controlled pain igram (mg) tablet every six (6)	F 309	will audit five (5) resident's pai sheets per week for twelve (12) to assure pain rate before and a intervention and location of pai documented, that the physician notified of any unrelieved or unacceptable levels of pain to the physician. The Director of Nursing of Manager will observe five (5) we dressing changes per week to as that the pain is relieved or at acc levels or the nurse stops treatment further intervention. The results audits will be reviewed with the Assurance Committee Monthly least three (3) months to assure compliance. If at any time conce identified, a Quality Assurance Committee will convene to revion make further recommendations needed. The Quality Assurance Committee will consist of at a r the Administrator, Director of M Assistant Director of Nursing, S Services Director with the Med Director attending at least quart	weeks fter n are was ne sing, r Unit vound ssure ceptable ent for of these e Quality for at ongoing erns are ew and as ninimum Jursing, Social ical	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

<u>CENIER</u>	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>0. 0938-0391_</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD				e survey Pleted
		185224	B. WING			06	/14/2013
NAME OF PF	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE.		
BOWLING	GREEN NURSING AND	REHABILITATION CENTER			BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X-5) COMPLETION DATE
	noted. Observation, on 06/12 Resident #1 was sittin completing physical th complained of his/her appeared uncomfortal Observation, on 06/12 staff member reported Registered Nurse (RN present. At 10:30 AM the wheelchair with fa Further observation, o revealed Resident #1 room. The resident ret still hurting "pretty bac Review of the Controll sheet, dated 06/12/13 administered Dilaudid of the MAR, dated Jur documentation of the I effectiveness of the m PM. Review of the Impaired dated 05/20/13, revea of pain during a treatm leave the resident safe Return to complete the	 k, but no rate of pain was k, but no rate of pain to k, the resident remained in the reatment, and seek pain relief. 	F	305			
	1:15 PM, revealed a m	sing change, on 06/12/13 at					

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Event ID:6L7211 Facility ID: 100409

If continuation sheet Page 18 of 26

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	OT ON MEDIOANE &					OWD IXC	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185224	B, WING			06/	14/2013
	OVIDER OR SUPPLIER	REHABILITATION CENTER		15	EET ADDRESS, CITY, STATE, ZIP CODE 61 NEWTON AVE. DWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	θE	(X5) COMPLETION DATE
	dressing. During the r resident was wincing i Further observation re appeared to be stuck was difficult to remove with visible tears rollin as RN #1 continued to #1 indicated the rosid "pre-medicated" and o dressing without imple intervention. Review of the Controll sheet, dated 06/13/13 administered Dilaudid of the MAR, dated Jur documentation of the effectiveness of the m Observation of a dress 10:00 AM, revealed of from four (4) wounds of Further observation re continuously stated "O treatment/dressing of revealed facial grimac during the treatment. T the other side while co please." Dressings we wounds on the resider treatment of these woo observed with the resi Throughout the treatment	emoval of the dressing, the in pain with facial grimacing. evealed the dressing to the resident's leg and a. The resident began to cry, ing down the resident's face, oremove the dressing. RN ent had been continued removing the ementing any other led Substance Proof of Use , revealed RN #1 4 mg at 8:00 AM. Review the 2013, revealed no location, rate of pain, or edication given at 8:00 AM. sing change, on 06/13/13 at d dressings were removed on the resident's right side. twealed Resident #1 0h" during the the wounds. Observation ing and complaints of pain fhe resident was rolled to ontinuously stating "Oh God, re removed from three (3) it's left side. During unds, facial grimacing was dent stating "Oh, please." tent of the wounds, RN #1 not helping?"-and-"We are	F	309			
		on you, isn't it?" it #1, on 06/13/13 at 5:30 dications were not effective					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 19 of 26

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	STON MEDICARE &	MEDICAID SERVICES				OND N	<u>J. 0936-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY PLETED
		185224	B, WING			06	/14/2013
	OVIDER OR SUPPLIER	REHABILITATION CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE.		
				1	BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id PREF TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ΞĒ	(X5) COMPLETION DATE
	better if staff give him. before the pain was s rate of pain during the an "8" out of "10." The "pretty bad" pain. Interview with Resider 06/13/13 at 5:30 PM, actually improved as t out" during treatments sometimes had to ask getting pain medication Interview with RN #1, and 3:00 PM, revealed given when asked on for the medication. Sh assessed and informe pain medication. Furth revealed she had not physician of the reside indicated Resident #1 treatments. She stated treatment before it ever resident had anxiety d the problem." She stated complained of pain be had to be due to the re revealed documentated included the location c and effectiveness; how the reason it was not c 06/13/13. She reveale management was effe	e resident stated it may be ther pain medications to bad. He/she revealed the treatment on 06/13/13 was e resident indicated that was ht #1's husband, on revealed the pain had he resident used to "squawl s. He indicated the resident three (3) times before ns. on 06/14/13 at 10:00 AM d pain medication was not 06/12/13 as it was not time e revealed the resident was d that it was not time for her interview with RN#1 notified the resident's ent's unrelieved pain. She always had pain during d the resident feared the isorder, which was "a lot of red when a resident fore touching them, then it esident's anxiety. She on of pain medications of the pain pain, rate of pain, vever, she was unsure of documented on 06/12/13 or d the resident's pain- ctive for him/her as the ring treatments on 06/12/13	F	309			
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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100409

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If continuation sheet Page 20 of 26

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED
		185224	B. MNG		06/14/2013
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104	
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	i0 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE
F 309	Interview with the Dire 06/14/13 at 4:45 PM, pain included the rate she expected staff to within the hour after a She felt the intervention plan were generic and individualized; however follow the intervention try non-pharmalogical time for pain medication continued to complain should be notified. Sh measures for relief du physician if pain continued An attempt to interview	ector of Nursing (DON), on revealed documentation of of pain. The DON stated reassess and document pain medication was given. ons on Resident #1's care I should have been more er, she still expected staff to s. She stated staff should interventions if it was not on but if a resident of pain, the physician e expected staff to try other ring treatments and call the nued. w Resident #1's primary at 10:35 AM, revealed he	F 30	2	
F 314 SS=D	at 2:00 PM, revealed A notify the physician if the effective during a treat 483.25(c) TREATMEN PREVENT/HEAL PRE Based on the compreter resident, the facility may who enters the facility does not develop press individual's clinical con- they were unavoidable pressure sores received	T/SVCS TO SSURE SORES tensive assessment of a ust ensure that a resident without pressure sores sure sores unless the dition demonstrates that ; and a resident having is necessary treatment and baling, prevent infection and	F 314	 F314 - Treatment/Svcs to Prevent/Heal Pressure Sores 1. The physician was notified of resident # 1's pressure ulcer on 6/13/13 by the Assistant Director of Nursing with an appropriate treatment put in place. 2. A complete skin assessment will be completed on all current residents by 7/28/13 by the Director of Nursing, Assistant Director of Nursing or Unit Manager. Any identified skin impairments will be reviewed to assure that the MD has been notified, documentation complete and an appropriate treatment if needed are in place. Any identified skin impairments that have not had MD notification or 	7/28/13

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 21 of 28

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PRINTED: 06/28/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION		OATE SURVEY COMPLETED		
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CO 1561 NEWTON AVE. BOWLING GREEN, KY 42104	DE			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NGY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETIO: DATE		
F 314	by: Based on observat and review of the fa determined the faci having pressure so treatment and servi one (1) of fourteen (Resident #1). A sk revealed the nurse on the resident's left scabbed area to the nurse did not asses physician of the new appropriate treatmen healing. The findings include Review of the Skin revised 08/08, rever observed skin was finding the problem using a formulary pu physician approval. be notified at the tim notification would be record. Record review rever Resident #1 on 03/2 included Peripheral Ulcer of the Leg, RF Joint, and Muscle-W significant change M dated 05/20/13, rever	NT is not met as evidenced tion, interview, record review, acility's policy/procedure, it was lity failed to ensure a resident res received necessary ces to promote healing for (14) sampled residents in assessment for Resident #1 identified a "red, mushy" area at heel, and a darkened beleft second toe; however, the as, document, or notify the w areas to ensure an ent was in place to promote set System policy/procedure, aled on admission and when compromised, the nurse would initiate a treatment roduct, if possible and Physician and family would	F 31-	that does not have an approver treatment in place, the facilic contact the physician for mand or treatment. 3. All Licensed Nurses will educated by the Director of Assistant Director of Nurses on assessing, documentation notification and appropriate for pressure ulcers. This rewill be completed by 7/28/Licensed Nurse working all without having receiving the the Director of Nursing Director of Nursing or Unit will complete a look behind assessment five (5) times proved the twelve (12) weeks. A look assessment is a skin assessment for any new skin impairments document impairment and notified the of any new skin impairment and notified the of any new skin impairment if new results of these audits will with the Quality Assurance Monthly for at least three (assurance Committee will review and make further recommendations as needed Quality Assurance Committee of Assistant Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of at a minimum the Administrator, Director of Nursing Consist of Statement of St	lity will otification II be re- f Nursing, ing, Unit e Consultant on, physician e treatment -education 13 with no fter 7/28/13 nis training. g, Assistant t Manager d skin er week for behind skin ment care nurse has nt to assure 1 any new ted the skin e physician its for eded. The be reviewed c Committee 3) months to a. If at any f, a Quality convene to d. The itee will e Nursing,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6L7211

Facility ID: 100409

If continuation sheet Page 22 of 26

		MEDICAID SERVICES	1		F	<u>0. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILOING			e survey Ipleted
		185224	B. WNG		06	\$/14/2013
NAME OF PF	OVIDER OR SUPPLIER		\$1	IREET ADDRESS, CITY, STATE, ZIP CO	DE	
BOWLING	GREEN NURSING AND	REHABILITATION CENTER		1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	jd PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 314	dated 03/20/13, revea resident at high risk for Observation, on 06/13 Resident #1 complain Upon observation by f the left heel was desc #1 made the statemer "propped up." Addition darkened scabbed are second toe. Record review, on 06/ no documentation of th resident's left heel or I no new treatments init Observation with the A (ADON), on 06/14/13 resident's left heel was The ADON revealed it The ADON revealed it The ADON left the roo assess the wound. Ap minutes later, yellow d bed as the "blister" has assessed the area as centimeters (cm) in ler assessed the darkene second toe as "unstag	led the facility identified the r pressure ulcers. 13 at 10:15 AM, revealed ed of pain to the left heel. Registered Nurse (RN) #1, ribed as "red, mushy." RN at the heel needed to be hally, RN #1 identified a aa on the resident's left 14/13 at 9:00 AM, revealed he area identified to the eft second toe. There were lated. Assistant Director of Nursing at 10:45 AM, revealed the s red and non-blanchable. was "boggy" underneath. m to obtain supplies to	F 314	Services Director with the	Medical	
	revealed she identified left heel, on 06/13/13, was made aware and notify the physician for	on 06/14/13 at 10:10 AM, the area to the resident's She revealed the ADON would be responsible to a treatment plan. She I pain to the left heel was	,			

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FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 23 of 26

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DEPARTMENT OF HEALTH AND HUMAN SERVICES TERO COD U

PRINTED: 06/28/2013 FORMAPPROVED

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STATEMENT	of Deficiencies F correction	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:				re survey Mpleted
		185224	B. WING			6/14/2013
	ROVIOER OR SUPPLIER	REHABILITATION CENTER	~L	STREET ADDRESS, C(TY, STATE, ZIP CO 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	id Prefjø Tag	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X6) COMPLETIO DATE
	not addressed as she significant. RN #1 rev scabbed area to the k on 06/13/13; however findings. She reveale been made aware. SI "probably" her respon of both areas, since s nurse. Interview with the AD/ AM, revealed she was identified areas on 06 should have assessed documented the wour physician for a treatm Interview with the Dire 06/14/13 at 4:45 PM, assessed and measu however, if new areas that nurse's responsib and notify the physicia 483.25(h) FREE OF A HAZARDS/SUPERVIS The facility must ensu environment remains as is possible; and ea adequate supervision prevent accidents.	did not feel it was ealed the darkened off second toe was identified off second toe was identified of the ADON should have the indicated it was sibility to notify the physician the was the identifying ON, on 06/14/13 at 10:45 is not aware of the newly /13/13. She revealed RN #1 d, measured, and tas, as well as notified the ent plan. Sector of Nursing (DON), on revealed the ADON red wounds weekly; were identified, it would be illity to assess, document, an for treatment. CCIDENT SION/DEVICES re that the resident as free of accident hazards ch resident receives and assistance devices to	F 3	F323 – Free of Accident Ha Supervision/Devices 1. The knife for resident # removed by a CNA on 6/12	12 was 2/13. s completed faintenance tify any uding e identified. re-educated ctor of of Nursing promoting a residents de knives n will be	7/28/13
	This REQUIREMENT	is not met as evidenced		Facility ID: 100409	If continuation sha	

If continuation sheet Page 24 of 26

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185224	B, WING			06/	14/2013
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		1	561 NEWTON AVE.		
DOMENIG	OREEN NORSING AND	REPART AND CENTER		В	OWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPF DEFICIENCY)	BE	(X5) Completion Date
F 323	Continued From page 24		F 32		working after 7/28/13 without having		
		2 - 7		323	received this education.		
	by: Report on observation	n and interview it was			4. The Administrator, Director of		
				Nursing, Assistant Director of Nursin			
ļ	determined the facility resident environment				or Unit Manager will complete weekl	у	
	accident hazards as is			audits for twelve (12) weeks of the			
			1		facility to assure that no unsafe object		
	resident's room.	observed being kept unsecured in a nt's room.			are unsecured. The Director of Nursin	lg,	
					Assistant Director of Nursing or Unit		
	The findings include:		ļ		Manager will complete a look behind	.	
	the mange molede.				skin assessment five (5) times per we		
	Review of the facility's	s Admission Agreement,			for twelve (12) weeks. A look behind		
	dated 07/01/12, revea				skin assessment is a skin assessment		
	responsibilities Sectio		I	completed after the direct care nurse l			
		any of his or her personal			completed a skin assessment to assure	;	
		local, State, Federal laws,		ĺ	that the nurse has identified any new	(
		or policies of the Center, the			skin impairments and notified the		
	Center has the right to	require the resident to		ł	physician of any new skin impairment	us.	
	remove them or to see	ek assistance from			The results of these audits will be		
	appropriate authorities	s to assist in the removal of			reviewed with the Quality Assurance		
****	such possessions".				Committee Monthly for at least three (3) months to assure ongoing		
ĺ	A record review revea	led Resident #12 was			compliance. If at any time concerns an	re	
		on 03/11/13 with diagnoses			identified, a Quality Assurance		
		ellitus and Congestive Heart			Committee will convene to review and	d	
		te admission Minimum Data			make further recommendations as		
1		d 03/18/13 revealed the			needed. The Quality Assurance		
1		esident as cognitively intact.			Committee will consist of at a minimu		
	There was no evidence	e an assessment was		[the Administrator, Director of Nursing	5,	
	completed to determin				Assistant Director of Nursing, Social Services Director with the Medical		
	resident to store knifes	s in his/her room.			Director attending at least quarterly.		
	Observation on 06/12/	/13 at 6:30 AM, during the			- · ·		
		esident #12 was in his/her		ŀ		l	
		ne-resident at this time	·······				
	revealed the resident v	was confused,					
	Observation on 06/12/	13 at 12:00 PM, revealed					
	the lunch meal being s						

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100409

If continuation sheet Page 25 of 26

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224			co	(X3) DATE SURVEY COMPLETED 06/14/2013	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	5	STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 323	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		F 32	23	D TO THE APPROPRIATE DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6L7211

Facility ID: 100409

If continuation sheet Page 26 of 26