

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

PRINTED: 11/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/25/2014
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p><b>**Amended**</b></p> <p>An Abbreviated/Partial Extended Survey investigating complaint #KY21953 was conducted on 07/29/14 through 08/07/14 to determine the facility's compliance with Federal requirements. Complaint #KY21953 was substantiated with deficiencies cited.</p> <p>After consultation with CMS and Supervisory review, F279, F282 and F329 were deleted and the survey was reopened to obtain additional information on 09/23/14 through 09/25/14. It was determined F280, F323 and F428 were raised to a Scope and Severity of a "J".</p> <p>Resident #2 was re-admitted to the facility on 04/08/14 from a psychiatric hospitalization with new orders for Haldol (anti-psychotic), five (5) milligrams (mg) twice a day. On 06/03/14, the Consultant Pharmacist recommended a trial dose reduction of the Haldol from five (5) mg to two and one half (2.5) mg; however, the physician was not made aware of the pharmacy recommendations per the facility's policy and procedure.</p> <p>On 06/12/14 at approximately 4:00 PM, Resident #2 had a fall with injury resulting in a fractured clavicle (collarbone). At the time of the fall, Resident #2 was noted to have a shuffling gait (a side effect of the Haldol). The physician was called and made aware of the shuffling gait and fall; however, the physician was still not made aware of the Pharmacy Consultant's recommendation to decrease the Haldol dosage. The physician ordered Cogentin to help with the</p>	F 000	<p>F 000</p> <p>This plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the party of NHC Madisonville to the accuracy of the Surveyor's findings nor the conclusions drawn therefrom. The facility's submission of the plan of Correction does not constitute an admission on the part of the facility thus the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p>	10/3/14



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Danny Belcher* TITLE: *ad* (X6) DATE: 11/12/14 10/23/2014

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 000	<p>Continued From page 1 side effects of the Haldol.</p> <p>On 06/15/14, three (3) days later, Resident #2 had a second fall, resulting in three (3) additional fractures to his/her arm, (humerus, ulna, and radius) and the physician was still not aware of the pharmacy's recommendation to consider a trial dose reduction of the Haldol. The physician was notified of the recommendation on 06/17/14, and decreased the Haldol dose to two (2) milligrams (mg) twice a day. The physician visited the resident on 06/19/14 and noted the resident had two (2) significant falls and was markedly lethargic. The physician discontinued the Haldol and the Cogentin. The resident was assessed as having a significant decline in ADLs and expired at the facility on 07/04/14.</p> <p>On 07/01/14, the facility assessed Resident #1 after he/she returned from the hospital as dependent on two (2) plus person physical assistance with bed mobility, transfer and ambulation in room; however, the facility failed to revise the care plan to address the resident's decline in condition. On 07/25/14, Resident #1 was lowered to the floor during a transfer when he/she was transferred by one (1) Certified Nursing Assistant (CNA) and sustained a right fractured fibula (leg bone).</p> <p>On 07/25/14, at 1:50 PM, Resident #1 was found by the Assistant Director of Nursing (ADON) and the Floor Nurse to be cyanotic (low oxygen causing bluish discoloration of the skin) and unresponsive. Resident #1's oxygen saturation was noted to be sixty-nine percent (69%) (normal 90-100%) on room air, blood pressure was 79/45 mm/hg (millimeters of mercury) (normal 118/68) and heart rate was 136 (normal 60-100). At 1:55</p>	F 000			

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F 000	<p>Continued From page 2</p> <p>PM, Resident #1's oxygen increased to eighty-five percent (85%) on four (4) liters of oxygen, blood pressure was 90/40 mm/hg, heart rate was eighty-five (85), and respiratory rate was twenty (20). At 2:25 PM, Resident #1's oxygen saturation was eighty-eight percent (88%); a text message was sent to the physician. There was no documented evidence the facility "called" the physician "immediately" to notify the physician of Resident #1's significant change in condition as per the facility's policy and procedures.</p> <p>At 3:45 PM, (approximately one (1) hour and fifty (50) minutes later) an order was received from the physician for labs and a chest x-ray. Further review revealed the resident was found at 5:30 PM, to be cyanotic with labored respirations, and his/her oxygen saturation was seventy-four percent (74%) on four (4) liters of oxygen. There was no documented evidence the facility conducted on-going assessments and monitoring of the resident for two (2) hours and fifty-five (55) minutes after the resident initially presented with the decreased oxygen saturations. The physician was called at that time and an order was received to send Resident #1 to the Emergency Room (ER). Resident #1 was admitted to the Critical Care Unit at the hospital on 07/25/14 with diagnoses of Dyspnea and Pneumonia. Resident #1 remained at the hospital in the Critical Care Unit and expired on 08/01/14.</p> <p>Immediate Jeopardy was identified in the areas of 483.10 Resident Rights; F-157; 483.20 Resident Assessment; F-279; and 483.25 Quality of Care; F-309 at a Scope and Severity of a "J". Substandard Quality of Care was identified at 483.25 Quality of Care. Immediate Jeopardy was identified on 08/07/14 and determined to exist on</p>	F 000			

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F 000	Continued From page 3 08/15/14. The facility was notified of the Immediate Jeopardy on 08/07/14.  An acceptable Allegation of Compliance (AoC) was received on 08/19/14, alleging the removal of Immediate Jeopardy on 08/16/14. The State Survey Agency validated, on 08/19/14-08/20/14, the Immediate Jeopardy was removed on 08/16/14, as alleged. The Scope and Severity was lowered to a "D" at 483.10 Resident Rights; F-157; 483.20 Resident Assessment; F-279; and, 483.25 Quality of Care; F-309, while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance Committee monitors the effectiveness of the system changes.  An AoC was received on 09/24/14, alleging removal of the Immediate Jeopardy on 08/29/14. The State Survey Agency validated, on 09/24-25/14, the Immediate Jeopardy was removed on 08/29/14, as alleged. The Scope and Severity was lowered to a "D" at 483.20 Resident Assessment; F-280; 483.25 Quality of Care F-323; and 483.60 Pharmacy Services F429, while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance Committee monitors the effectiveness of the system changes. F157 and F309 remained at a Scope and Severity of a "D".	F 000			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in	F 157			

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F 157	<p>Continued From page 4</p> <p>injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policies and procedures, and review of a Hospital Emergency Room (ER) Note, it was determined the facility failed to immediately consult with the physician for two (2) of nine (9) sampled residents (Resident #1 and Resident #2).</p> <p>On 07/25/14 at approximately 1:50 PM, Resident #1 was found to be unresponsive and cyanotic</p>	F 157	<p>F157:</p> <ul style="list-style-type: none"> <li>On 07/25/14 Resident #1 was discharged from the facility to local hospital. The patient expired on 08/01/14 at the hospital. The final diagnosis is not yet available per the hospital Medical Record department. No action was able to be taken to correct the deficient practice for this resident.</li> <li>Resident sample #2 expired 07/04/14. No action was able to be taken to correct the deficient practices for this resident.</li> <li>Upon the instruction of the Regional Nurse and Director of Nursing on 08/07/14, vital signs of 100% of all residents were taken by RN, LPN, and CNA staff. Vital signs included B/P, respiration rate, pulse, temperature, and O2 saturations, to determine if residents presented with vital signs outside established parameters. "Established Parameters" are O2 saturations 90% or above, blood pressure 20 points (mm/Hg) above or below 120/80 (normally accepted values), pulse below 60 or above 100</li> </ul>		

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F 157	<p>Continued From page 5</p> <p>(low oxygen causing bluish discoloration of the skin and a late sign of low oxygen levels in the blood) by the Assistant Director of Nursing (ADON) and Floor Nurse. The resident's oxygen saturation was sixty-nine percent (69%, normal 90-100), blood pressure was 79/45 mm/Hg (millimeters of mercury), (normal 118/68) and heart rate was 136 beats per minute (bpm) (normal 60-100). The facility failed to call the physician immediately per the facility's policy and procedure. At 2:25 PM, approximately thirty-five (35) minutes later, the facility sent the physician a text message. A Physician's Order was received approximately one (1) hour and fifty (50) minutes later, at 3:45 PM, to obtain labs and a chest x ray. The resident was noted again, at 5:30 PM, to have oxygen saturations of seventy-four percent (74%), labored respirations, and his/her skin was cyanotic. The physician was phoned and a new order was received to send Resident #1 to the Emergency Room. Resident #1 was admitted to the Critical Care Unit with the diagnoses of Dyspnea and Pneumonia. The resident expired at the acute care hospital on 08/01/14.</p> <p>Resident #2 was re-admitted to the facility on 04/08/14 from a psychiatric hospitalization with new orders for Haldol (antipsychotic) five (5) milligrams (mg) twice a day. On 06/03/14, the Consultant Pharmacist performed the monthly medication regimen review and recommended a trial dose reduction of the antipsychotic medication, Haldol, from five (5) mg to two and one half (2.5 mg), two (2) times daily. However, the physician was not made aware of the Pharmacy's Consultant's recommendation.</p> <p>Resident #2 had a fall on 06/12/14 at approximately 4:00 PM, which resulted in a</p>	F 157	<p>(normally established heart rate), respirations above 20 breaths per minute or below 12 breaths per minute (normally established respiration rate), and a temperature above 99 degrees F (normally established temperature). Any vital signs outside of these parameters were repeated/re-checked on 8/8/14 by RN or LPN Team Leader. It is important to note, that no vital signs taken on 8/7/14 or early am 8/8/14 were critical or of any imminent danger to any resident. There were no "emergency" vital signs. The vital signs were also compared to the resident's baseline vital signs to determine what intervention, if any, needed to be taken. The comparison to baseline vital signs were made by the DON, RN/LPN Team Leaders on 8/8/14. The baseline was established from previously recorded routine vitals found in each resident's medical record. Nursing notes for any resident who received a vital sign re-check were completed by the RN or LPN Team Leader on 8/8/14 through 8/11/14. No residents were found to be in need of additional interventions at that time.</p>	
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F 157	<p>Continued From page 6</p> <p>non-displaced fracture of his/her left clavicle (collarbone). Resident #2 was noted to have a shuffling gait at the time of this fall (a side effect of the Haldol). The physician was notified of the shuffling gait, and he ordered Cogentin to help reduce the side effects of the Haldol. However, the facility failed to make the physician aware of the Consultant's recommendation to do a drug reduction for the Haldol.</p> <p>Resident #2 had a second fall three (3) days later on 08/15/14, resulting in three (3) additional fractures of his/her arm (humerus, radius, and ulna). The physician was still not made aware of the Consultant Pharmacy Recommendation to consider a trial dose reduction. There was no documented evidence the physician was made aware of the recommendation until 08/17/14, at that time, a Physician's Order was received to decrease the Haldol dose to two (2) milligrams (mg) twice a day.</p> <p>The facility's failure to notify and consult with the physician immediately when the resident had a significant change in condition has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/07/14 and was determined to exist on 08/15/14.</p> <p>The findings include:</p> <p>1. Review of the facility's policy and procedure titled, "Care of Critically Ill Patient/Significant Change in Medical Condition", not dated, revealed when a significant change in medical condition has occurred or the resident is assessed to be critically ill, the attending physician will be notified immediately.</p>	F 157	<p>In addition, on 8/9/14, 100% of all residents receiving oxygen, residents with a respiratory diagnosis, and residents with Congestive Heart Failure diagnosis were focused on for a respiratory assessment by the DON, RN/LPN team leaders. The respiratory assessment included vital signs, O2 saturations, lung sounds, and observation of cough if any, and in addition, any resident complaints. One (1) resident received an order from his/her physician on 8/9/14 for a chest x-ray, with results negative for significant findings, and a medication order for Solumedrol to treat COPD was received on 8/10/14 by RN MDS Coordinator.</p> <p>A review of 100% of all consultant pharmacy recommendations was completed on 8/28/14 going back to 7/1/14. All recommendations were acted upon within 14 days of writing, as was the policy/practice of that time. No other residents were affected by the deficient practice.</p> <ul style="list-style-type: none"> <li>• Upon the instructions of the Administrator, in-service training was conducted for the RN and LPN staff</li> </ul>		

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F 157	<p>Continued From page 7</p> <p>Review of the facility's policy and procedure titled, "When to Call the Physician Immediately", not dated, revealed that acute changes in vital signs included an increase or decrease in heart rate, respirations, blood pressure, labored breathing, a drop in oxygen saturations, or any other significant changes in the resident's status.</p> <p>Review of the facility's policy and procedure titled, "Change in Patient Status", last revised 03/08/13, revealed in an emergency situation the charge nurse will render appropriate care to the resident, notify the physician, and transfer the patient as appropriate. In addition, the policy stated in the event of an acute change in medical condition and the attending physician was unavailable the nursing partner would take steps necessary to assure appropriate medical intervention.</p> <p>Record review revealed the facility admitted Resident #1 on 10/24/13 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Chronic Kidney Disease, and Hypertension.</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment, dated 05/08/14, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable.</p> <p>Review of a Nurse's Note, dated 06/13/14 at 1:00 PM, revealed Resident #1 was found to have removed his/her oxygen and further review revealed Resident #1 was educated to leave nasal canula in place. Review of a Nurse's Note, dated 07/20/14 at 4:00 AM, revealed the resident</p>	F 157	<p>beginning 8/8/14 by the DON, Respiratory Therapist, and an Advanced Practice Nurse. The training for the RN/LPN staff included the following topics: performing a proper respiratory assessment and documentation, "Emergency Care of the Resident" per NHC Policy, when to send a resident to a higher level of care (hospital), nursing assessment and correct nursing documentation/follow up of a patient in crisis, which included when to notify the physician and how to notify the physician of a patient whose status has changed.</p> <p>Specifically on 8/8/14, the DON provided an in-service with Department Heads and Nursing Management (RNs and LPNs) on results of survey/review of findings. This was lecture style, including handouts. This was repeated on 8/9/14 through 8/11/14 with 100% of all nursing staff; RN, LPN, and CNA. One licensed nurse on leave was reviewed by phone, as well as two (2) other licensed nurses on 8/12/14 and 8/13/14.</p> <p>A Respiratory Therapist conducted a lecture based in-service on 8/8/14 and</p>	

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F 157	<p>Continued From page 8</p> <p>"keeps taking oxygen off". However there was no documented evidence this was addressed in Resident #1's care plan and no documented evidence the facility had made the physician aware.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 07/29/14 at 12:45 PM, revealed Resident #1 had behaviors of taking his/her oxygen off. CNA #1 stated Resident #1 would do this to go to the hospital.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 07/29/14 at 3:04 PM, revealed Resident #1 was non compliant with care at times. She further stated Resident #1 takes the oxygen off at times and we just remind him/her to put it back on.</p> <p>Interview with Registered Nurse (RN) #1, on 08/06/14 at 8:55 AM, revealed Resident #1 did have a history of taking oxygen off but did not know why he/she did this.</p> <p>Interview with the Resident #1's Physician, on 08/01/14 at 8:30 AM, revealed that he was not aware of Resident #1 constantly removing his/her oxygen.</p> <p>Review of a Nurse's Note, dated 07/25/14 at 1:50 PM, revealed Resident #1 was found in his/her bed to be cyanotic and unresponsive. The resident's oxygen saturation was noted to be sixty-nine percent (69%), (normal 90-100), blood pressure was 79/45 mm/Hg, (normal 118/68) and heart rate was 136 bpm (normal 60-100). There was no documented evidence the physician was called immediately to notify her of the resident's significant change in condition related to the</p>	F 157	<p>8/11/14 for all licensed nurses. All nurses were in attendance with 2 nurses who were reviewed by phone with LPN Team Leader on 8/12/14 and one nurse on leave at time, via phone by LPN team leader on 8/13/14. Handouts were given which included signs of severe respiratory distress, signs of imminent respiratory distress, vital sign assessments/pulse oximetry.</p> <p>Beginning on 8/8/14 the DON provided in-servicing to all licensed nurses on "Emergency Care of the Resident" which included when to send a resident to the hospital, assessment of respiratory condition of resident and documentation of same.</p> <p>In the event the attending physician or the physician on call does not respond at the time the call placed when a patient is in crisis, the RN and LPN staff was instructed by the DON to call 911. 100% of all RN's and LPN's on staff received the training. In-service training was completed with the RN and LPN staff on 8/12/14.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/25/2014
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 418 NORTH SEMINARY ST MADISONVILLE, KY 42431		
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F 157	<p>Continued From page 9</p> <p>acute change in vital signs as indicated by an increase or decrease in heart rate, respirations, blood pressure, labored breathing, a drop in oxygen saturations, or any other significant changes in the patient's status as per the facility's policy and procedure.</p> <p>Review of a Nurse's Note, dated 07/25/14 at 1:55 PM, revealed the resident's oxygen saturation increased to eighty-five percent (85%) on oxygen at four (4) liters per minute and his/her blood pressure was noted to be 90/50 mm/Hg. Review of a Nurse's Note, dated 07/25/14 at 2:25 PM, revealed the oxygen saturation was noted to be eighty-eight (88%) and the physician was sent a text message; however, there was still no documented evidence the physician was called per the facility's policy and procedure due to the low blood pressure and oxygen saturation rate.</p> <p>Review of a Nurse's Note, dated 07/25/14 at 3:45 PM, revealed a new order was received approximately one-hour and thirty minutes after the text message to obtain labs and a chest x-ray. At 5:30 PM, approximately three (3) hours and thirty-five (35) minutes after the resident was first identified with the significant change in condition, Resident #1 was noted to be cyanotic, with labored respirations and an oxygen saturation of seventy-four percent (74%) on oxygen at four (4) liters per nasal cannula. The Physician was notified and Resident #1 was sent to the Emergency Room (ER).</p> <p>Review of a Hospital ER Note, dated 07/25/14, revealed Resident #1 was placed on a non-rebreather mask with fifteen (15) liters of oxygen when he/she arrived in the ER. Resident #1 was admitted to the Critical Care Unit with</p>	F 157	<p>One (1) licensed nurse was on leave at time with in-servicing being conducted by phone by the DON on 8/12/14.</p> <p>One newly hired RN was incerviced on the aforementioned topics prior to assuming duties.</p> <p>The facility does not employ agency/contract staff.</p> <p>All residents with variation in vital signs from baseline have been investigated further by the DON or LPN team leader or LPN team leader on each unit by chart review, medication review, and care plan review to determine the need for physician intervention. The investigation began on 8/9/14 and was completed on 8/14/14. There were no patients in crisis or with unstable findings. The attending physicians were notified beginning 8/9/14 of any vital sign variation by the RN team leader or LPN team leader on each unit for orders on those residents. Physician orders were processed by the RN team leader or LPN team leader on those residents as physicians felt were indicated and documented in the record.</p>		

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F 157	<p>Continued From page 10</p> <p>diagnoses of Dyspnea and Pneumonia.</p> <p>Review of a Provisional Report of Death revealed Resident #1 expired on 08/01/14 at the hospital. The Provisional Report of Death did not reveal the resident's diagnosis or the cause of death.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/06/14 at 2:48 PM, revealed she was making rounds on 07/25/14 at approximately 1:50 PM, and as she approached Resident #1's room she noted the resident had oxygen tubing "coiled up" around his/her hand. The ADON stated after she placed the oxygen back on Resident #1, he/she was able to state his/her name, the time, and place. The ADON revealed she administered an "as needed" (PRN) albuterol nebulizer treatment between 1:50 PM and 1:55 PM; however, she failed to document this information in the Nurse's Notes or on the Medication Administration Record (MAR). Additionally, the ADON stated she was in the room with the resident for approximately twenty (20) minutes. She stated, "I gave instructions for Registered Nurse (RN #1) to notify the physician; however, I was not aware RN #1 had sent a text message instead of calling the physician."</p> <p>Interview with Registered Nurse (RN) #1, on 07/31/14 at 8:33 AM; and, on 08/06/14 at 8:55 AM, revealed she worked on 07/25/14 during the day shift and was Resident #1's nurse. RN #1 stated the ADON called her to Resident #1's room and as she entered the room, the ADON was putting oxygen on Resident #1, who was cyanotic and unresponsive. She stated "we had to do a sternal rub, pat the resident and work with him/her a little to get him/her to respond." RN #1 stated she later sent the physician a text</p>	F 157	<p>Additionally, 24 hour reports from 8/1/14 through 8/12/14 were reviewed by the Regional Nurse to ensure all physicians were notified of any change of condition. All residents on the 24 hour report did have the physician notified by the RN or LPN caring for the resident at the time of change in condition. This review was completed by the Regional Nurse on 8/12/14.</p> <p>On 8/8/14 the DON met with the consultant Pharmacist to review the correct practice of pharmacy recommendation review. The following guidelines were agreed upon by the Consultant Pharmacist, Director of Nurses, Medical Director and Administrator.</p> <ol style="list-style-type: none"> <li>1. The consultant pharmacist will print recommendations prior to exiting the facility.</li> <li>2. Recommendations will be given to the DON or in the DON's absence, to the Administrator.</li> <li>3. The DON will distribute copies of the recommendations to the appropriate Team Leader by the next business day.</li> </ol>		

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F 157	<p>Continued From page 11</p> <p>message to inform him of Resident #1's status. She stated according to her message history on her cell phone, the message was not sent to the physician until 3:15 PM rather than 2:25 PM, as the Nurse's Note had stated. RN #1 stated she did not send Resident #1 out to the hospital because the resident stated he/she did not want to go. She further stated Resident #1 was his/her own guardian. However, she was not sure the resident was capable of making that decision and she did not consider this at that time. In addition, she stated the physician had responded to the text message at 3:45 PM with new orders and when Resident #1's oxygen saturations "started coming up (oxygen saturation of 88%), I felt like we could manage (him/her) here." RN #1 stated, "When we identify a change in condition, we try to notify the physician as soon as possible, but we take care of the resident first."</p> <p>Interview with Licensed Practical Nurse (LPN) #1, Team Leader on Resident #1's unit, on 07/31/14 at 9:47 AM, revealed her expectation and the facility's policy was to call the physician when a resident had a change in condition. She further stated the resident comes first, in a crisis situation, "I would expect the nurse to send the resident out to the hospital and then notify the MD."</p> <p>Interview with the Director of Nursing (DON), on 08/07/14 at 3:25 PM, revealed her expectation was for the staff to phone the resident's physician immediately when a significant change had been identified. She stated the nurse should not have sent a text message in that situation. The DON stated she expected the nurse to have sent the resident out to the hospital when she assessed the resident to be cyanotic and unresponsive.</p>	F 157	<p>4. The Team Leader will contact the attending physician to obtain a response to the recommendation. Recommendations will be returned to the DON with seven (7) days of receipt of the recommendation.</p> <p>5. The DON will track and monitor recommendations to assure a timely response and follow up to the recommendations.</p> <p>The revised practice was reviewed with the team leaders on 8/8/14 and instituted.</p> <p>The physicians will no longer be notified by placing the recommendation in their communication folder.</p> <p>The ADON is no longer employed by the facility.</p> <p>Nurse #1 is no longer employed by the facility.</p> <ul style="list-style-type: none"> <li>On August 8/11/2014 the Regional Nurse reviewed with the Director of Nursing, the Quality Assurance</li> </ul>		

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F 157	<p>Continued From page 12</p> <p>The DON stated the facility did not have a policy that addressed what to do if a resident refused to be sent to the hospital.</p> <p>Interview with the Administrator, on 08/07/14 at 4:04 PM, revealed his expectation in a crisis situation was for the staff to phone the physician and do what they needed to do to rescue the resident, and the next thing would be to transfer the resident out to the hospital.</p> <p>Interview with Resident #1's Physician, on 08/01/14 at 8:30 AM, revealed the resident had an order for continuous oxygen at two (2) to four (4) liters to maintain his/her oxygen saturations above 92%. The Physician stated Resident #1 had a history of his/her oxygen saturations dropping and when they dropped, he/she would be sent out to the hospital. The Physician revealed when the nurse assessed the resident to be cyanotic, and unresponsive with unstable vital signs, the resident should have immediately been sent to the Emergency Room (ER) at that time.</p> <p>2. Record review revealed the facility re-admitted Resident #2 on 04/08/14 with diagnoses which included Senile Dementia, Hallucinations, Adjustment Disorder with Anxiety, Diabetes Mellitus, and Hypertension.</p> <p>Review of a Significant Change MDS assessment, dated 04/17/14, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of eight (8).</p> <p>Review of a Physician's Order, dated 04/08/14, revealed an order for Haldol five (5) mg twice a day.</p>	F 157	<p>Monitors that began 8/10/14.</p> <p>Monitors reviewed included:</p> <p>On 8/10/14 the DON began a monitor to ensure completion of daily assessment of resident's respiratory status and documentation of same on all residents' with respiratory related diagnosis, daily for seven days. The RN/LPN team leaders will monitor each affected resident's chart to ensure documentation and follow-up as needed which may include notification of physician. After the 7 days, the DON will determine which residents need to remain on daily assessment of respiratory status and changes based on findings and documentation. Those residents deemed necessary will again be monitored for respiratory status by the RN/LPN team leaders for 7 additional days to ensure assessment and documentation compliance by licensed nurses. This will be ongoing every 7 days until compliance is determined by the DON and Quality Assurance Committee.</p> <p>A mock "code" situation of a resident in respiratory distress was conducted on 8/9/14 at 1 pm to evaluate</p>	

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F 157	<p>Continued From page 13</p> <p>Review of a Consultant Pharmacy Recommendation, dated 06/03/14, revealed a recommendation for the physician to consider a trial dose reduction of Haldol to assess the lowest effective dose, with a recommendation to decrease the dose from five (5) milligram (mg) to two and a half milligram (2.5 mg) twice a day. Further review revealed no documented evidence the facility notified the physician of the pharmacy's recommendation at that time.</p> <p>Review of a Falls Investigation Summary, dated 06/13/14, revealed Resident #2 had a fall on 06/12/14 and at the time of the fall the resident was observed shuffling his/her feet which caused him/her to fall. The physician was notified of the fall and the shuffling gait with orders to administer Cogentin to help reduce the side effect (shuffling gait) of Haldol. However, there was no documented evidence the physician was made aware of the Consultant's Pharmacy Recommendation to decrease the dosage of Haldol.</p> <p>Review of a Post Falls Investigation, dated 06/17/14, revealed the resident had an unwitnessed fall on 06/15/14 at approximately 3:45 AM, while ambulating in the hall unattended. Resident #2 was assessed immediately after the fall and was noted to have complaints of pain to his/her right arm, rating the pain as a ten (10) out of ten (10) on the pain scale. The resident was transferred to the Emergency Room.</p> <p>Review of a Hospital Emergency Room (ER) Note, dated 06/15/14, revealed diagnoses of fractured humerus, fractured radius and fractured ulna. Further review revealed an order was</p>	F 157	<p>appropriateness of response and action. The "code" situation of a resident in respiratory distress was conducted by the DON to RN and LPN staff. Staff responded timely within 1 minute to crisis situation and acted accordingly by obtaining vital signs, assessing the resident and intervening as appropriate and simulating a phone call to the physician. All actions were completed within 3 minutes. Mock codes of similar situations involving patients in respiratory distress will continue weekly, unannounced and varying times and shifts x 6 weeks, then, re-evaluation to determine future frequency. These will be conducted by the DON and RN Team Leader. Mock codes will be conducted on 7-3, 3-11, 11-7 shifts.</p> <p>100% of all RN and LPN staff were verbally interviewed, one on one, 8/12/14 and 8/13/14 by DON or Regional Nurse to determine their understanding of when and how physician notification is done, in the event of a resident in medical crisis. Verbal "one on one" interviews will continue for the RN and LPN staff with</p>	

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F 157	<p>Continued From page 14</p> <p>written for an arm sling and splint and to refer the resident to the Orthopedic Surgeon.</p> <p>Review of a Physician's Note, dated 06/19/14, revealed Resident #2's physician visited him/her at the facility and noted the resident had two (2) significant recent falls resulting in fractures. The physician assessed the resident to be markedly lethargic and confused and discontinued the Haldol and the Cogentin.</p> <p>Interview with the Consultant Pharmacist, on 08/01/14 at 1:04 PM, revealed Haldol was an antipsychotic medication and it was not the first choice of medications to use in older adults. She stated the side effects of the Haldol could include Extrapyramidal Symptoms (EPS) such as shuffling gait, abnormal movements and gait disturbance. She revealed the side effects of Haldol were generally abrupt in nature but may develop at any time. She stated Cogentin was used to control side effects of the Haldol but if EPS side effects developed the appropriate thing to do was ask for a reduction. She stated, "If the physician had agreed to the trial dose reduction at the time of the recommendation (recommendation was 06/03/14 and first fall was 06/12/14), it was possible the fall could have been avoided.</p> <p>Interview with Resident #2's Physician, on 08/01/14 at 9:12 AM, revealed he did not recall being made aware of the pharmacy's recommendation to decrease the Haldol dosage at the time of Resident # 2's falls.</p> <p>Interview with the Assltant Director of Nursing (ADON), on 07/30/14 at 2:22 PM, revealed she phoned the physician to inform him of the</p>	F 157	<p>5 interviews per week for 5 weeks to repeat the interviews for all RN and LPN staff, a second time. The interviews will be conducted by the DON. The one (1) licensed nurse on leave was interviewed prior to his/her return to work. The facility does not employ agency/contract staff. The above interviews conducted by the DON for the RN and LPN staff will continue on going as needed, dependent on outcome as advised by the QA committee.</p> <p>A respiratory monitor to observe for correct O2 flow, O2 signs, clean and dated tubing, tubing off the floor, O2 saturation monitoring and care plan accuracy was begun on 8/14/14 for 100% of all residents receiving oxygen therapy by the Regional Nurse. These monitors will continue weekly on 100% of all residents on oxygen therapy. Monitors will be completed by the Respiratory Therapist or DON, and will continue until QA committee deems compliance achieved.</p> <p>Daily rounding and observation of 100% of all residents by the DON/RN team leaders, and charge nurses on all</p>	

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F 157	<p>Continued From page 15</p> <p>resident's fall and the shuffling gait; however, she did not make the physician aware of the pharmacy's recommendation. She stated, "I reported the shuffling gait, and he ordered Cogentin for the side effects of Haldol."</p> <p>Interview with the Director of Nursing (DON), on 08/07/14 at 3:37 PM, revealed the ADON should have made the physician aware of the pharmacy's recommendations at the time of the first fall.</p> <p>Interview with the Administrator, on 08/07/14 at 4:14 PM, revealed the physician should have been made aware of the pharmacy recommendation at the time of the first fall.</p> <p><b>**The facility implemented the following actions to remove the Immediate Jeopardy:</b></p> <ol style="list-style-type: none"> <li>1. On 08/07/14, the facility obtained the vital signs of one hundred percent (100%) of all the residents. This was done by the Registered Nurse (RN), Licensed Practical Nurse (LPN) and the Certified Nursing Assistant (CNA) staff. The vital signs included blood pressure (B/P), respiration rate, pulse, temperature, and oxygen saturations to determine if residents presented with vital signs outside established parameters. (B/P 20 points (mm/Hg) above or below 120/80, pulse below 60 or above 100, respirations above 20 breaths per minute or below 12 per minute, and a temperature above 99 degrees Fahrenheit.)</li> <li>2. On 08/09/14, one hundred percent (100%) of all residents receiving oxygen, residents with a respiratory diagnosis, and residents with</li> </ol>	F 157	<p>shifts provide opportunities for observation that specified care is being provided and resident needs are being met. Additionally, the Medication Administration Records, Treatment Administration Records, 24-hour reports, physician orders, and verbal communications validate systems are in place and the care is being provided for all residents according to care plans for 100% of all residents.</p> <p>Review of all consultant pharmacist recommendations continue to be reviewed to assure compliance with 7 day guidelines, as well as, physician response to recommendations.</p> <p>Pharmacy recommendations will be monitored by the DON for completions weekly until 100% compliance achieved and QA Committee deems appropriate.</p> <p>All Quality Assurance Monitors will be reported to the center's Quality Assurance Committee consisting of the Medical Director, Administrator, Director of Nursing, Medical Records Director, Dietary Manager, Social Worker, Housekeeping Supervisor, and Activities Director. The Director of</p>		

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F 157	<p>Continued From page 16</p> <p>Congestive Heart Failure received respiratory assessments by the DON, RN/LPN team leaders. The respiratory assessments included vital signs, oxygen saturations, lung sounds, and observations for any cough or additional complaints.</p> <p>3. On 08/08/14-08/13/14, the Director of Nursing (DON) provided an in-service to one hundred percent (100%) of the facility's RNs, LPNs and CNAs regarding the results of the survey/review findings. The DON provided additional in-services to all licensed nurses on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation, which was also completed on 08/13/14. In addition, a Respiratory Therapist provided in-service to all licensed nurses regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse/ oxygen which was completed on 08/13/14.</p> <p>4. On 08/12/14, the Regional Nurse reviewed the twenty-four (24) hour reports to ensure the physician was notified of all residents with a change of condition from 08/01/14-08/12/14.</p> <p>5. Quality Assurance Monitors began the week of 08/10/14, which included audits of respiratory status/documentation for all residents with respiratory related diagnosis daily, for seven (7) days. In addition, on 08/09/14, the facility began mock "code" situations to evaluate the appropriateness of response and action by facility staff. Additionally, on 08/12/14-08/13/14, the facility verbally interviewed one hundred percent (100%) of all RN and LPN staff regarding when and how to notify the physician in the event of a</p>	F 157	Nursing will be responsible to report to the committee. Training and Quality Assurance monitors will continue as directed by the Quality Assurance Committee.	10/3/14	

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F 157	<p>Continued From page 17</p> <p>medical crisis. An additional five (5) weeks of monitoring was added with five (5) interviews per week for five (5) additional weeks. Additional Quality Assurance Monitors included audits to observe the correct oxygen flow, oxygen signs, clean and dated tubing, oxygen tubing off the floor, oxygen saturation monitoring and care plan accuracy which began, on 08/14/14, for one hundred percent (100%) of all residents receiving oxygen therapy by the Regional Nurse.</p> <p>The State Survey Agency validated the Corrective Action taken by the facility as follows:</p> <ol style="list-style-type: none"> <li>1. Interview with the Director of Nursing (DON), on 08/20/14 at 2:04 PM, revealed the facility obtained the vital signs of one hundred percent (100%) of all the residents on 08/07/14. Review of the facility's Vital Sign Audit tool revealed one hundred percent of all the residents had his/her vital signs assessed on 08/07/14.</li> <li>2. Review of the facility's Respiratory Assessment Audit Tool revealed that each resident with a respiratory diagnosis or a diagnosis of Congestive Heart Failure received a full respiratory assessment each shift for seven (7) days starting on 08/04/14.</li> </ol> <p>Interview with the RN Team Leader (RN #5), on 08/20/14 at 9:46 AM, the LPN Team Leader (LPN #10), on 08/20/14 at 10:04 AM, and the LPN Team Leader (LPN #1), on 08/20/14 at 10:22 AM, revealed respiratory assessments were completed on their halls daily. They stated the Nurse's Notes were reviewed for accuracy in documentation and the results of the respiratory assessment were also documented on the audit tool for Quality Assurance.</p>	F 157			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185D15	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/25/2014
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
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F 157	<p>Continued From page 18</p> <p>3. Review, on 08/19/14, of the inservice logs, dated 08/08/14, 08/09/14, 08/10/14, 08/11/14, and 08/13/14, revealed all staff was inserviced related to emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further review, revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse/oxygen</p> <p>Interviews with CNA #3, CNA #4, and CNA #2, on 08/20/14 at 9:06 AM, 9:12 AM, and 9:16 AM, respectively, revealed they had received in-servicing regarding the survey results.</p> <p>Interviews, on 08/19/14, with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM; and, on 08/20/14 with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM, LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been in-serviced regarding the survey results. In addition, they stated they also received in-services on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further interview revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse/oxygen</p> <p>Interviews with RN #4 on 08/19/14 at 3:45 PM; and, on 08/20/14 with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had received inservicing regarding the survey results. In addition, they stated they also</p>	F 157			

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F 157	<p>Continued From page 19</p> <p>received in-services on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further interview revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assesment/pulse/oxygen.</p> <p>4. Interview with the Regional Nurse Consultant, on 08/20/14 at 12:24 PM, revealed she reviewed the twenty-four hour (24) reports on 08/12/14 to ensure all residents who were on the 24 hour report, had the appropriate physician notification. Review of the audit reports for the physician notification revealed residents identified with a change of condition received appropriate physician notification.</p> <p>5. Review of facility audits, dated 08/09/14, on all residents with a respiratory diagnosis revealed the residents received daily assessments for seven (7) days to include assessments of mentation, vital signs, oxygen saturation, skin color and temperature, oxygen device and flow rate, quality of respirations and lung sounds, presence of chest pain or cough and for the presence of any additional subjective complaints.</p> <p>Review of the facility's audit reports, dated 08/14/14, revealed the facility conducted audits regarding residents who were receiving oxygen to observe for the correct oxygen flow, oxygen door signs, clean and dated tubing, oxygen tubing off the floor, oxygen saturation monitoring and care plan accuracy, beginning on 08/14/14, for one hundred percent (100%) of all residents receiving oxygen therapy by the Regional Nurse.</p>	F 157			

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F 157	Continued From page 20 Interview with the Regional Nurse Consultant, on 08/20/14 at 12:24 PM, revealed she performed an audit on all residents receiving oxygen to observe for the correct oxygen flow, appropriate placement of oxygen signs, clean and dated oxygen tubing, observed for oxygen tubing off the floor, oxygen saturation monitoring and the care plan was accurate and appropriate for all residents receiving oxygen.  Interviews on 08/19/14, with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM, and interviews on 08/20/14 with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM, LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the LPNs revealed the Director of Nursing (DON) was conducting random mock "code" situations to monitor and evaluate the appropriateness of response and action by the facility's licensed staff.  Interviews with RN #4 on 08/19/14 at 3:45 PM, and on 08/20/14 with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the RN staff revealed the Director of Nursing (DON) was conducting random mock "code" situations to monitor and evaluate the appropriateness of response and action by the facility licensed staff.	F 157			
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 21</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview, record review, review of the facility's policy and procedures, and review of the Hospital's History and Physical, it was determined the facility failed to review and revise one (1) of nine (9) sampled residents' (Resident #1) care plan to reflect the resident's significant change in condition and the resident's non-compliance with wearing his/her oxygen.</p> <p>Resident #1 was re-admitted to the facility on 07/01/14. The facility assessed Resident #1 as requiring two (2) staff for transfers; however, the facility failed to ensure the care plan reflected the assessment findings. On 07/12/14, Resident #1 was transferred from the bed to his/her recliner by</p>	F 280	<p>F280</p> <ul style="list-style-type: none"> <li>On 7/25/14 Resident #1 was discharged from the facility to the local hospital. The patient expired on 8/01/14 at the hospital. The final diagnosis is not yet available per the hospital Medical Record department. No action was able to be taken to correct the deficient practice for this resident.</li> <li>Beginning on 8/8/14 a 100% review of all resident care plans was begun and completed by the RN MDS Coordinators on 8/12/14 for 100% of all resident care plans with known diagnosis of COPD, CHF, those residents receiving oxygen therapy, or other dyspnea related diagnosis. The RN MDS Coordinators reviewed these care plans to ensure problems and interventions were addressed as appropriate. Changes were made by RN MDS Coordinators as required and completed by 8/12/14.</li> <li>In addition, a 100% audit of all residents who have returned to the facility post hospitalization beginning with 7/1/14 was completed by RN MDS Coordinators on 8/14/14 to ensure care needs are reflected in the care plan</li> </ul>		

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F 280	<p>Continued From page 22</p> <p>one (1) staff and became too weak to stand and had to be lowered to the floor. The resident sustained a fracture of the right fibula (leg) as a result of the fall.</p> <p>In addition, Resident #1 had a Physician's Order for oxygen therapy. The resident was care planned to administer oxygen as ordered and the Physician's Order stated to maintain the resident's oxygen saturation level at ninety-two percent (92%). On 07/25/14 at approximately 1:50 PM, Resident #1 was found in his/her bed by the Assistant Director of Nursing (ADON) with the nasal cannula "coiled up" around his/her hand. The resident was cyanotic (low oxygen causing bluish discoloration of the skin). The resident's oxygen saturation was sixty-nine percent (69%) and his/her oxygen was not in place. Interviews with the direct care staff revealed the resident had a history of being non-compliant and removing his/her oxygen; however, the care plan did not address this problem and there was no system in place to monitor the resident's oxygen.</p> <p>The facility's failure to review and revise the care plan has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/07/14 and was determined to exist on 07/25/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Documentation Guidelines/Care Plans", dated 01/01/05, revealed care plan approaches should be specific and individualized to assist the resident to achieve a goal. The approaches are the instructions for providing resident care and ensuring the continuity of care.</p>	F 280	<p>accurately. Care plans for post hospitalization residents were updated as needed based on individual care needs by the RN MDS Coordinators.</p> <p>100% of all residents have had their care plans reviewed and updated as needed by the DON, RN/LPN team leaders, and RN MDS Coordinators. The updates were completed by the DON, RN/LPN team leaders, and RN MDS Coordinators on 8/15/14. A recap of 100% of all resident's current physician orders including nursing tasks, fall interventions, treatments, code status, therapy orders, diet orders, adaptive equipment, and labs were printed and these were compared to the current care plan to ensure the interventions listed on physician orders were included in the care plan.</p> <ul style="list-style-type: none"> <li>Upon the instructions of the administrator, in-service training was conducted beginning 8/8/14 by the DON. The training included the following topics: Updating care plan problems based on resident condition/changes, updating care plan interventions as new orders/changes</li> </ul>		

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F 280	<p>Continued From page 23</p> <p>Record review revealed the facility admitted Resident #1 on 10/24/13 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Chronic Kidney Disease, and Hypertension.</p> <p>Review of a Significant Change Minimum Data Set (MDS) Assessment, dated 05/08/14, revealed the facility assessed Resident #1 as cognitively intact, with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. Further review revealed the facility assessed Resident #1 to require the extensive assistance of two (2) plus persons physical assistance for bed mobility.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 05/20/14, revealed an intervention to transfer with the assistance of one (1) to two (2) staff instead of the assessed need of two (2) staff; and, the resident was at risk for signs and symptoms of cardiac/respiratory distress. Interventions included administer oxygen as ordered, check oxygen saturations as needed, observe for signs and symptoms of COPD and intervene as needed, and to observe for signs and symptoms of respiratory distress and report.</p> <p>Review of a Hospital Discharge Summary, dated 07/01/14, revealed Resident #1 was hospitalized from 06/21/14 through 07/01/14 related to the diagnoses of Congestive Heart Failure, Respiratory Failure, and Abdominal Pain.</p> <p>Review of a Re-Admission Nursing Assessment, dated 07/01/14, revealed the facility assessed Resident #1 as totally dependent on two (2) plus person, physical assistance for transfer.</p>	F 280	<p>occur, updating care plans upon return from the hospital, and updating CNA care plans with any changes on the medical record care plan. All RNs and LPNs on staff received the training. In-service training was completed by the DON with the RNs and LPNs on staff on 8/12/14. One (1) licensed nurse was on leave at time with in-servicing being conducted by phone by the DON on 8/12/14.</p> <p>One newly hired RN was incerviced on the aforementioned topics prior to assuming duties.</p> <p>The facility does not employ agency/contract staff.</p> <p>100% of all CNAs were in-serviced by the DON and RN/LPN team leaders beginning on 8/8/14 on care plan location and CNA responsibility to review information for updates on care plans. Those CNAs not in attendance were contacted by phone by the DON, RN/LPN team leaders, or RN MDS Coordinators on 8/13/14. All CNAs verbally verified their understanding of the in-service to the DON, RN/LPN team leaders or RN MDS Coordinators.</p>	

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F 280	<p>Continued From page 24</p> <p>Additionally, Resident #1 was assessed to have severe pitting edema to all extremities, and the resident was unable to transfer from the bed to wheelchair to be weighed. However, further review of the Comprehensive Care Plan, dated 05/20/14, revealed the care plan still reflected the need for one (1) to two (2) staff for transfers.</p> <p>Review of a Post Falls Nursing Assessment, dated 07/14/14, revealed Resident #1 had to be lowered to the floor by a Certified Nursing Assistant (CNA) while transferring him/her from the bed to a chair on 07/12/14 at 9:30 AM with no injuries identified at the time. The CNA was transferring the resident without assistance.</p> <p>Review of a Nurse's Note, dated 07/12/14 at 8:55 PM, revealed the facility assessed the resident to have an oxygen saturation of eighty-four percent (84%) on four (4) liters of oxygen. The physician was notified and the resident was sent to the Emergency Room (ER) via ambulance.</p> <p>Review of a Hospital History and Physical, dated 07/13/14, revealed Resident #1 complained of right ankle pain and shortness of breath when he/she arrived at the hospital. An x-ray was conducted which revealed a displaced spiral fracture of the distal fibula.</p> <p>Interview with CNA #1, on 07/29/14 at 12:45 PM, revealed she had entered Resident #1's room to provide personal care. She stated Resident #1 was in his/her bed and had requested to stand up for a minute because he/she had not been out of bed since he/she had been back from the hospital. CNA #1 stated she assisted Resident #1 to stand at the bedside for approximately three (3) to four (4) minutes, then asked Resident #1 if</p>	F 280	<p>100% of all residents who returned to the facility from the hospital will have their care plans reviewed by the admitting licensed nurse upon the resident's re-admission and by the RN MDS Coordinator within 72 hours to ensure any new problems, goals, and interventions have been added or updated.</p> <p>100% of all newly written physician orders will be printed every morning by the RN MDS Coordinator or RN/LPN team leaders, or the RN licensed nurse who works weekends to ensure the resident's care plan was updated as indicated. Any discrepancies noted will be corrected by any RN/LPN.</p> <p>One newly hired RN was in-serviced on care plan updating prior to duties on floor.</p> <ul style="list-style-type: none"> <li>On August 11, 2014, the Regional Nurse reviewed with the Director of Nursing the Quality Assurance Monitors that began on 8/10/14. Monitors reviewed included: 100% of all licensed nurses (RN and LPN) were verbally interviewed, one on</li> </ul>	

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F 280	<p>Continued From page 25</p> <p>he/she would like to sit in his/her recliner while she made the bed and the resident agreed. Further interview revealed when the resident went to pivot, his/her knee gave out and she (CNA #1) assisted the resident to the floor as much as she possibly could. She stated Resident #1 landed on his/her knees with his/her feet under him/her. CNA #1 stated she had to get the nurse and two (2) additional aides to assist her to get the resident back to bed. She stated the resident didn't complain of pain, but said she was "shaken up". CNA #1 stated, "Honestly, I didn't know the resident had been in the hospital and had a decline." She stated she was not normally assigned to Resident #1 and it had been a little while since she had worked with him/her.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 07/31/14 at 1:11 PM, revealed she was the nurse on duty at the time of Resident #1's fall. She stated she was called to the room by one of the CNAs to assist with getting the resident back in bed. The LPN stated it took several people to get the resident back in bed. She stated once Resident #1 was back in bed, she immediately did a head to toe skin assessment including range of motion on all extremities, and a full pain assessment. She revealed the assessment was baseline for the resident with no complaints of pain to the lower extremities. LPN #2 stated she checked on the resident approximately thirty (30) minutes after the fall and then was in and out of the resident's room the rest of the day. She stated at approximately 8:45 PM, when she entered the resident's room for the medication pass, the resident was "kind of shaky" and had decreased alertness. She stated she obtained the resident's oxygen saturations and it was eighty-four percent (84%). She stated the</p>	F 280	<p>one, by the DON and Regional Nurse on 8/12/14 and 8/13/14 to determine their understanding of care plan updates based on resident need. The licensed nurse on leave was interviewed prior to his/her return to work. The facility does not employ agency/contract staff.</p> <p>Daily, 100% of all newly written physician orders and telephone orders will be reviewed by the RN/LPN team leaders to ensure all residents who have received any physician orders have had their care plans reviewed and updated. Monitoring will be conducted by the DON ongoing weekly, x 5 weeks, and reported monthly to the Quality Assurance Committee until the Quality Assurance Committee determines compliance. This began on 8/12/14 and will continue.</p> <p>CNAs will be interviewed by RN/LPN team leaders 12 per week, x 5 weeks, to ensure their understanding of care plans. By the end of the 5 weeks, all CNAs will have been interviewed a second time to ensure their continued understanding of care plans. The RN/LPN team leaders will conduct the</p>	

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F 280	<p>Continued From page 26</p> <p>resident did not complain of any pain. LPN #2 stated she phoned the physician and sent the resident to the Emergency Room (ER) via ambulance.</p> <p>Interview with Registered Nurse (RN) #2, on 07/30/14 at 3:38 PM, revealed she was the nurse who completed the re-admission assessment for Resident #1. She stated the resident required a lot of care due to the Congestive Heart Failure (CHF) and Chronic Pulmonary Disease (COPD). RN #2 revealed Resident #1 had chronic pain and fluid overload. She stated the resident had been able to transfer and ambulate with the assistance of one (1) staff member before the hospitalization. RN #2 stated she thought the CNAs would get two (2) staff if it was needed; therefore, she did not update the Comprehensive Care Plan.</p> <p>Interview with CNA #2, on 07/29/14 at 1:16 PM, revealed she was the primary CNA for Resident #1 most of the time. She stated the resident had gotten weaker since the most recent hospitalization. She stated, "Now I am doing everything for the resident because (he/she) just can't do it." Further interview revealed she was no longer able to get the resident up to use the bedside commode per the care plan. CNA #2 stated, "I just put the resident on the bed pan." Additionally, CNA #2 stated the resident used to be able to transfer with the assistance of one (1), but he/she needed two (2) staff now.</p> <p>Further review of the Nurse's Notes revealed on 07/25/14 at 1:50 PM, Resident #1 was found in his/her bed to be cyanotic and he/she was not wearing his/her oxygen. The resident was assessed to have oxygen saturations of sixty-nine</p>	F 280	<p>interviews ongoing until the QA committee determines compliance.</p> <p>Daily rounding and observations on 100% of all residents by the DON, RN/LPN team leaders and charge nurses provide opportunities for observation that specified care is being provided and resident needs are being met. Additionally, the Medication Administration Records, Treatment Administration Records, 24-hour reports, physician orders, and verbal communications validate systems are in place and the care is being provided for all residents according to care plans for 100% of all residents</p> <p>All Quality Assurance Monitors will be reported to the center's Quality Assurance Committee consisting of the Medical Director, Administrator, Director of Nursing, Medical Records Director, Dietary Manager, Social Worker, Housekeeping Supervisor, and Activities Director. The Director of Nursing will be responsible to report to the committee. Training and Quality Assurance monitors will continue as</p>		

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F 280	<p>Continued From page 27</p> <p>percent (69%). In addition, his/her blood pressure was 79/45 mm/Hg (millimeters of mercury) and the heart rate was 138 (normal range 60-100). Oxygen was placed on the resident at that time at four (4) liters per nasal cannula. At 1:55 PM, Resident #1's oxygen saturations increased to eighty-five percent (85%) on four (4) liters per nasal cannula and at 2:25 PM, the resident's oxygen saturation was eighty-eight percent (88%). However, at 5:30 PM, the resident's oxygen saturations was seventy-four percent (74%) on four (4) liters of oxygen. The resident was sent to the Emergency Room (ER).</p> <p>Review of an ER Note, dated 07/25/14, revealed Resident #1 was admitted to the Critical Care Unit with diagnoses of Dyspnea and Pneumonia. Review of a Provisional Report of Death revealed Resident #1 expired on 08/01/14 at the hospital.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/06/14 at 2:48 PM revealed she was making rounds on 07/25/14 at approximately 1:50 PM, and as she approached Resident #1's room she noted the resident was holding the oxygen tubing "coiled up" around his/her hand. The ADON stated she called for the floor nurse who was also in the hall. The ADON stated after she placed the oxygen back on Resident #1, he/she was able to state his/her name, time, and place.</p> <p>Interview with Registered Nurse (RN) #1, on 07/31/14 at 8:33 AM; and, on 08/06/14 at 8:55 AM, revealed she worked on 07/25/14 during the day shift and was Resident #1's nurse. RN #1 stated Resident #1 did have behaviors of taking his/her oxygen off. She stated, "I don't know why</p>	F 280	directed by the Quality Assurance Committee.	10/3/14	

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F 280	<p>Continued From page 28 (he/she) does that."</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 07/29/14 at 12:45 PM, revealed Resident #1 would hold his/her breath at times to make his/her oxygen saturation "go down" and would take his/her oxygen off at times. She stated the resident would do this, "to go back to the hospital."</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 07/29/14 at 3:04 PM, revealed Resident #1 was non-compliant with his/her care at times and would take his/her oxygen off at times. She stated, "I have sent (him/her) to the Emergency Room (ER) two (2) times for this since the first of July."</p> <p>Further review of the Comprehensive Care Plan, dated 05/20/14, revealed there were no interventions to address Resident #1's removing his/her oxygen and no interventions to address monitoring the resident to ensure the resident's oxygen was in place.</p> <p>Interview with RN #3, MDS Coordinator, on 07/30/14 at 9:43 AM, revealed when a resident was readmitted to the facility from the hospital, the nurse completing the re-admission assessment would update the care plan based on any necessary changes and if a MDS was done, it would be reviewed at that time. In addition, she stated the care plan was developed based on the resident's current conditions and diagnoses. She revealed the care plan would be updated by the nurse taking care of the resident.</p> <p>Interview with the Director of Nursing (DON), on 08/07/14 at 3:25 PM, revealed she expected care</p>	F 280		
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F 280	<p>Continued From page 29</p> <p>plans to be updated based on the resident's current assessed needs. In addition, she stated, "The expectation was, the care plan should be updated when there had been a change in condition or a status change."</p> <p>Interview with the Physician, on 08/01/14 at 8:30 AM, revealed Resident #1 was a very non-compliant resident and had multiple comorbid diagnoses. He stated staff had not made him aware the resident had behaviors of taking the oxygen off. He revealed that he attended care plan meetings and the nurses were very good at keeping him informed. He stated when the resident's oxygen saturations would drop we would send him/her out to the hospital.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. On 08/12/14, the RN MDS Coordinator completed a review of all residents at the facility with known diagnoses of COPD, CHF, residents receiving oxygen and residents with other dyspnea related diagnoses. The care plans were reviewed to ensure the care plans appropriately addressed the problems and interventions. Additionally, the RN MDS Coordinator completed an audit on 100% of all residents who had returned to the facility post hospitalization beginning 07/01/14 to ensure appropriate care needs were reflected in the care plan accurately.</li> <li>2. On 08/15/14, the Director of Nursing, the RN MDS Coordinator, and the RN/LPN Team Leaders conducted a review of 100% of all care plans with 100% of all physicians orders, nursing interventions, fall interventions, treatment orders,</li> </ol>	F 280		

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F 280	<p>Continued From page 30</p> <p>code status, therapy orders, diet orders, adaptive equipment, and labs orders were accurate and appropriately addressed in the care plan.</p> <p>3. The Director of Nursing conducted inservice training to all licensed staff regarding updating care plan problems based on resident condition changes, updating care plan interventions as new orders/changes occur, updating care plans upon return from the hospital and updating CNA care plans with any changes on the medical record care plan. All RNs and LPNs were inserviced which was completed on 08/12/14.</p> <p>4. 100% of all CNAs were inserviced by the DON and RN/LPN Team Leaders beginning on 08/08/14 related to care plan location and CNA responsibility to review information for updates on the care plan.</p> <p>The State Survey Agency validated the Corrective Action taken by the facility as follows:</p> <p>1. Review of the facility's audit of all residents with known diagnoses of COPD, CHF, residents receiving oxygen and residents with other dyspnea related diagnoses, dated 08/12/14, revealed all care plans were reviewed and updated. Additionally, review of the audit dated 08/15/14, revealed 100% of all residents who returned to the facility post hospitalization had care plans reviewed to ensure appropriate care plan needs were accurate.</p> <p>Interview with the RN MDS Coordinator, RN #3 on 08/20/14 at 10:56 AM, revealed she reviewed the care plans of all residents with the known diagnoses of COPD, CHF, residents receiving</p>	F 280			

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F 280	<p>Continued From page 31</p> <p>oxygen and residents with other dyspnea related diagnoses to ensure the care plans were accurate and appropriate. In addition, she stated she reviewed all residents re-admitted to the facility post hospitalized from 07/01/14 to 08/15/14 to ensure accurate and appropriate care plans.</p> <p>2. Review of a facility's audit dated 08/15/14, revealed all care plans were reviewed and updated for 100% of all residents to include physician orders, nursing interventions, fall interventions, treatment orders, code status, therapy orders, diet orders, adaptive equipment and lab orders to ensure appropriateness and accuracy.</p> <p>Review of Resident #10's, Resident #11's, Resident #12's, and Resident #13's record revealed the care plans were updated with no concerns noted related to care plans.</p> <p>Interview with the RN Team Leader, RN #5, on 08/20/14 at 9:46 AM, revealed she completed the care plan audit on 08/15/14. She stated all physician orders were printed and they were compared to the care plan to ensure accuracy and appropriateness.</p> <p>Interview with the LPN/ Team Leader, LPN #1, on 08/20/14 at 10:22 AM, and LPN #10 on 08/20/14 at 10:04 AM, revealed all physician orders were printed and compared to the care plan to ensure accuracy and appropriateness.</p> <p>Interview with the RN MDS Coordinator, RN #3, on 08/20/14 at 10:56 AM, revealed all physician orders were printed and they were compared to the care plan to ensure accuracy and</p>	F 280			

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F 280	<p>Continued From page 32 appropriateness.</p> <p>Interview with the Director of Nursing, on 08/20/14 at 2:04 PM, revealed she along with the MDS Coordinator and the RN/LPN Team Leaders reviewed 100% of all care plans to ensure accuracy</p> <p>3. Review of a facility inservice log, dated 08/08/14 and 08/12/14, revealed all staff was inserviced regarding updating care plan problems based on resident condition changes, updating care plan interventions as new orders/changes occur, updating care plans upon return from the hospital and updating CNA care plans with any changes on the medical record care plan.</p> <p>Interviews on 08/19/14, with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM, and interviews on 08/20/14 with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM, LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been inserviced regarding updating care plan problems based on resident condition changes, updating care plan interventions as new orders/changes occurred, updating care plans upon return from the hospital and updating CNA care plans with any changes on the medical record care plan.</p> <p>Interviews with RN #4 on 08/19/14 at 3:45 PM; and, on 08/20/14 with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the RN staff revealed the Director of Nursing was conducting random mock "code" situations to monitor and evaluate the appropriateness of</p>	F 280			

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F 280	Continued From page 33 response and action by the facility licensed staff.  4. Review of a facility inservice log revealed 100% of all CNAs were inserviced by the DON and RN/LPN Team Leaders beginning on 08/08/14 through 08/20/14 related to care plan location and CNA responsibility to review information for updates on the care plan.  Interviews with CNA #3, CNA #4, and CNA #2, on 08/20/14 at 9:06 AM, 9:12 AM, and 9:18 AM, respectively, revealed they had been inserviced related to care plan location and CNA responsibility to review information for updates on the care plan.	F 280	F309  On 7/25/14 Resident #1 was discharged from the facility to a local hospital. The patient expired on 8/1/14 at the hospital the final diagnosis is not yet available per the hospital Medical Record department. No action was able to be taken to correct the deficient practice for this resident.  Upon the instruction of the Regional Nurse and Director of Nursing on 08/07/14, vital signs of 100% of all residents were taken by RN, LPN, and CNA staff. Vital signs included B/P, respiration rate, pulse, temperature, and O2 saturations, to determine if residents presented with vital signs outside established parameters. "Established Parameters" are O2 saturations 90% or above, blood pressure 20 points (mm/Hg) above or below 120/80 (normally accepted values), pulse below 60 or above 100 (normally established heart rate), respirations above 20 breaths per minute or below 12 breaths per minute (normally established respiration rate), and a temperature above 99 degrees F (normally established temperature).		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and procedure, review of the Hospital Emergency Room Note, and review of a Provisional Report of Death, it was determined the facility failed to ensure each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in	F 309			

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F 309	<p>Continued From page 34</p> <p>accordance with the plan of care for one (1) of nine (9) sampled residents (Resident #1). The facility failed to provide ongoing assessments and monitoring for Resident #1 when a significant change in condition was identified.</p> <p>On 07/25/14, at approximately 1:50 PM, Resident #1 was found in his/her room by facility staff unresponsive and cyanotic (low oxygen causing bluish discoloration of the skin). The resident's oxygen saturation was sixty-nine percent (69%) (normal 90-100) on room air, blood pressure was 79/46 (normal 118/68), and heart rate was 136 (normal 60-100) beats per minute (bpm). There was no documented evidence the physician was called to notify her of the resident's significant change in condition; however, at 2:25 PM, thirty-five (35) minutes later, a text message was sent to the physician. At 3:45 PM, a Physician's Order was received to obtain labs and a chest x-ray.</p> <p>At 5:30 PM, approximately three (3) hours and ten (10) minutes after the resident's significant change in condition, Resident #1 was noted to be cyanotic, with labored respiration and an oxygen saturation of seventy-four percent (74%). The Physician was notified and a new order was received to send Resident #1 to the Emergency Room (ER). The resident was transferred to the hospital where he/she was admitted to the Critical Care Unit with the diagnoses of Dyspnea and Pneumonia. The resident expired at the hospital on 08/01/14. (Refer to F-157)</p> <p>The facility's failure to ensure each resident received necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with</p>	F 309	<p>Any vital signs outside of these parameters were repeated/re-checked on 8/8/14 by RN or LPN Team Leader. It is important to note, no vital signs taken on 8/7/14 or early am 8/8/14 were critical or of any imminent danger to any resident. There were no "emergency" vital signs. The vital signs were also compared to the resident's baseline vital signs to determine what intervention, if any, needed to be taken. The comparison to baseline vital signs were made by the DON, RN/LPN Team Leaders on 8/8/14. The baseline was established from previously recorded routine vitals found in each resident's medical record. Nursing notes for any resident who received a vital sign re-check were completed by the RN or LPN Team Leader on 8/8/14 through 8/11/14. No residents were found to be in need of additional interventions at that time.</p> <p>In addition, on 8/9/14, 100% of all residents receiving oxygen, residents with a respiratory diagnosis, and residents with Congestive Heart Failure diagnosis were focused on for a respiratory assessment by the DON,</p>	

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F 309	<p>Continued From page 35</p> <p>the plan of care has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/07/14 and determined to exist on 07/25/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedures titled, "Care of Critically Ill Patient/Significant Change in Medical Condition", not dated, revealed that when a significant change in medical condition has occurred or the resident is assessed to be critically ill, the attending physician will be notified immediately.</p> <p>Review of the policy titled, "When to Call the Physician Immediately", not dated, revealed acute changes in vital signs includes an increase or decrease in heart rate, respirations, blood pressure, labored breathing, a drop in oxygen saturations, or any other significant changes in the resident's status.</p> <p>Review of the facility's policy and procedure titled, "Change in Patient Status", revised 03/06/13, revealed in an emergency situation the charge nurse will render appropriate care to the resident, notify the physician, and transfer the patient as appropriate. In addition, the policy stated in the event of an acute change in medical condition and the attending physician was unavailable the nursing partner will take steps necessary to assure appropriate medical intervention.</p> <p>Record review revealed the facility admitted Resident #1 on 10/24/13 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Chronic Kidney Disease, and Hypertension.</p>	F 309	<p>RN/LPN team leaders. The respiratory assessment included vital signs, O2 saturations, lung sounds, and observation of cough if any, and in addition, any resident complaints. One (1) resident received an order from his/her physician on 8/9/14 for a chest x-ray, with results negative for significant findings, and a medication order for Solumedrol to treat COPD was received on 8/10/14 by RN MDS Coordinator.</p> <ul style="list-style-type: none"> <li>Upon the instructions of the Administrator, in-service training was conducted for the RN and LPN staff beginning 8/8/14 by the DON, Respiratory Therapist, and an Advanced Practice Nurse. The training for the RN/LPN staff included the following topics: performing a proper respiratory assessment and documentation, "Emergency Care of the Resident" per NHC Policy, when to send a resident to a higher level of care (hospital), nursing assessment and correct nursing documentation/follow up of a patient in crisis, which included when to notify the physician and how to notify the</li> </ul>		

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F 309	<p>Continued From page 36</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment, dated 05/08/14 revealed the facility had assessed Resident #1 as cognitively intact with a Brief Interview Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan, dated 05/20/14, revealed Resident #1 was at risk for signs and symptoms of cardiac/respiratory distress with interventions that included administer oxygen as ordered, check oxygen saturations as needed, observe for signs and symptoms of COPD and intervene as needed and observe for signs and symptoms of respiratory distress and report.</p> <p>Review of the Physician's Orders, dated 07/01/14 through 07/13/14, revealed "Oxygen 2 - 4 liters to keep sats above 92%".</p> <p>Review of a Hospital Discharge Summary, dated 07/19/14, revealed Resident #1 was hospitalized on 07/12/14 through 07/19/14 with Acute onset Chronic Respiratory Failure. The facility re-admitted Resident #1 on 07/19/14.</p> <p>Review of a Nurse's Note, dated 07/25/14 at 1:50 PM, revealed Resident #1 was found in his/her bed unresponsive and cyanotic with an oxygen saturation of sixty-nine percent (69%) on room air, blood pressure was 79/45 and heart rate was 136 bpm. Oxygen was placed on the resident at four (4) liters per nasal cannula. There was no documented evidence the physician was called and notified of the resident's significant change in condition per the facility's policy and procedures.</p>	F 309	<p>physician of a patient whose status has changed.</p> <p>Specifically, on 8/8/14, the DON provided an in-service with Department Heads and Nursing Management (RNs and LPNs) on results of survey/review of findings. This was lecture style, including handouts. This was repeated on 8/9/14 through 8/11/14 with 100% of all nursing staff; RN, LPN, and CNA. One licensed nurse on leave was reviewed by phone, as well as two (2) other licensed nurses on 8/12/14 and 8/13/14.</p> <p>A Respiratory Therapist conducted a lecture based in-service on 8/8/14 and 8/11/14 for all licensed nurses. All nurses were in attendance with exception of 2 nurses who were reviewed by phone with LPN Team Leader on 8/12/14 and one nurse on leave via phone by LPN team leader on 8/13/14. Handouts were given which included signs of severe respiratory distress, signs of imminent respiratory distress, vital sign assessments/pulse oximetry.</p>		

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431	
(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 309	<p>Continued From page 37</p> <p>Further review of the 07/25/14 Nurse's Notes revealed the resident's oxygen saturation was eighty-eight percent (88%) on four (4) liters of oxygen at 2:25 PM and a text message was sent to the physician. At 3:45 PM, new orders were received for labs and a chest x ray. Review of a Nurse's Note at 5:30 PM, revealed Resident #1 was noted to have an oxygen saturation of 74%, labored respirations, and the resident's skin was again noted to be cyanotic. The physician was notified at that time and an order was received to send Resident #1 to the Emergency Room (ER). However, there was no documented evidence the facility assessed the resident from 2:25 PM to 5:30 PM.</p> <p>Review of an Emergency Room (ER) Note, dated 07/25/14, revealed Resident #1 was noted to have an altered mental status and was in moderate distress. The resident was placed on a non-rebreather mask with fifteen (15) liters of oxygen. The resident was admitted to the Critical Care Unit with diagnoses of Dyspnea and Pneumonia. The resident expired on 08/01/14 at the hospital in the Critical Care Unit.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/06/14 at 2:48 PM, revealed she was making routine rounds and as she approached Resident #1's room she noted that the resident had the oxygen tubing "coiled up" around his/her hand. She stated she saw the resident's nurse, who was also in the hallway, and summoned her to Resident #1's room. Further interview with the ADON revealed after she placed the oxygen back on Resident #1, the resident was able to state his/her name, time, and place. The ADON revealed she administered an as needed (PRN) albuterol nebulizer treatment</p>	F 309	<p>Beginning on 8/8/14 the DON provided in-servicing to all licensed nurses on "Emergency Care of the Resident" which included when to send a resident to the hospital, assessment of respiratory condition of resident and documentation of same.</p> <p>In the event the attending physician or the physician on call does not respond at the time the call placed when a patient is in crisis, the RN and LPN staff was instructed by the DON to call 911. 100% of all RN's and LPN's on staff received the training. In-service training was completed with the RN and LPN staff on 8/12/14.</p> <p>One (1) licensed nurse was on leave at time with in-servicing being conducted by phone by the DON on 8/12/14. The facility does not employ agency/contract staff.</p> <p>One newly hired RN was incerviced on all aforementioned topics prior to assuming duties on floor.</p> <p>All residents with variation in vital signs from baseline have been investigated further by the DON or LPN team leader or LPN team leader on each unit by chart review, medication review, and</p>	

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F 309	<p>Continued From page 38</p> <p>between the time of 1:50 PM and 1:55 PM but did not document this in the Nurse's Notes or on the Medication Administration Record (MAR). She stated she should have documented the medication. The ADON stated Resident #1 did not want to be sent out to the hospital. Further interview revealed the ADON stated the resident was monitored as she "checked on the resident throughout the day, and the Certified Nursing Assistants perform every two (2) hour checks, so someone was in and out of the room all the time".</p> <p>Interview with Registered Nurse (RN) #1, on 07/31/14 at 8:33 AM; and, on 08/08/14 at 8:55 AM revealed she had worked on 07/25/14 during the day shift and was the nurse for Resident #1. RN #1 stated she was summoned to Resident #1's room by the Assistant Director of Nursing (ADON) who was standing at the resident's doorway. RN #1 revealed she entered the room, and the ADON was putting oxygen on Resident #1. RN #1 stated Resident #1 was cyanotic and unresponsive and "we had to do a sternal rub, pat (him/her) and work with (him/her) a little to get (him/her) to respond. Just a few minutes after the ADON put the O2 on the resident, (his/her) O2 sats came up to 85%". Further interview with RN #1 revealed she did not send Resident #1 out to the hospital because the resident stated he/she did not want to go. She further stated Resident #1 was his/her own guardian; however, she was not sure the resident was capable of making that decision, but she did not consider that at the time. Further interview revealed, she continued to monitor Resident #1 throughout the day, she stated, "I was going back in (his/her) room every little bit to make sure that (his/her) oxygen was on because (he/she) would take it off." She further revealed, she continued to observe Resident #1's</p>	F 309	<p>care plan review to determine the need for physician intervention. The investigation began on 8/9/14 and was completed on 8/14/14. There were no patients in crisis or with unstable findings. The attending physicians were notified beginning 8/9/14 of any vital sign variation by the RN team leader or LPN team leader on each unit for orders on those residents. Physician orders were processed by the RN team leader or LPN team leader on those residents as physicians felt were indicated and documented in the record.</p> <p>Additionally, 24 hour reports from 8/1/14 through 8/12/14 were reviewed by the Regional Nurse to ensure all physicians were notified of any change of condition. All residents on the 24 hour report did have the physician notified by the RN or LPN caring for the resident at the time of change in condition. This review was completed by the Regional Nurse on 8/12/14.</p> <p>On 8/11/2014 the Regional Nurse reviewed with the Director of Nursing, the Quality Assurance Monitors that</p>		

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F 309	<p>Continued From page 39</p> <p>color, and obtained his/her oxygen saturation. She stated, "I was concerned about (his/her) oxygen saturations being a little low; however, I felt like Resident #1 was making an improvement." In addition, RN #1 revealed she did not document the assessments in the resident's medical record; however, no explanation was provided as to why this was not completed.</p> <p>Interview with Resident #1's Physician, on 08/01/14 at 8:30 AM, revealed the resident was legally competent; however, was very non-compliant and had multiple comorbid diagnoses. He stated the physician orders for the resident was for continuous oxygen at two (2) to four (4) liters to maintain oxygen saturations above 92%. The Physician revealed Resident #1 had a history of his/her saturations dropping and when they would, they would send him/her out to the hospital. The Physician stated when the nurse assessed the resident to be cyanotic, unresponsive with unstable vitals, the resident should have been sent out immediately to the ER at that time.</p> <p>Interview with the Director of Nursing, (DON) on 08/07/14 at 3:25 PM, revealed that based on the documentation the resident was not capable of determining if he/she was going to the hospital. Further interview revealed the DON stated, "I do expect the staff should have sent the resident out to the hospital, absolutely". She stated the facility did not have a policy to address what to do when a resident refused to be sent to the hospital. Additionally, she stated the nurse should have not sent a text message to the physician and should have phoned him immediately.</p>	F 309	<p>began 8/10/14. Monitors reviewed included:</p> <p>On 8/10/14 the DON began a monitor to ensure completion of daily assessment of resident's respiratory status and documentation of same on all residents with respiratory related diagnosis, daily for seven days. The RN/LPN team leaders will monitor each affected resident's chart to ensure documentation and follow-up as needed which may include notification of physician. After the 7 days, the DON will determine which residents need to remain on daily assessment of respiratory status and changes based on findings and documentation. Those residents deemed necessary will again be monitored for respiratory status by the RN/LPN team leaders for 7 additional days to ensure assessment and documentation compliance by licensed nurses. This will be ongoing every 7 days until compliance is determined by the DON and Quality Assurance Committee.</p> <p>A mock "code" situation of a resident in respiratory distress was conducted on 8/9/14 at 1 pm to evaluate</p>	

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F 309	<p>Continued From page 40</p> <p>Interview with the Administrator, on 08/07/14 at 4:04 PM, revealed he expected the staff to phone the physician in a crisis situation, rescue the resident, and transfer the resident out to the hospital.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. On 08/07/14, the facility obtained the vital signs of one hundred percent (100%) of all the residents. This was done by the Registered Nurse (RN), Licensed Practical Nurse (LPN) and the Certified Nursing Assistant (CNA) staff. The vital signs included blood pressure (B/P), respiration rate, pulse, temperature, and oxygen saturations to determine if residents presented with vital signs outside established parameters. (B/P 20 points (mm/Hg) above or below 120/80, pulse below 60 or above 100, respirations above 20 breaths per minute or below 12 per minute, and a temperature above 99 degrees Fahrenheit.</li> <li>2. On 08/09/14, one hundred percent (100%) of all residents receiving oxygen, residents with a respiratory diagnosis, and residents with Congestive Heart Failure received respiratory assessments by the DON, RN/LPN team leaders. The respiratory assessments included vital signs, oxygen saturations, lung sounds, and observations for any cough or additional complaints.</li> <li>3. On 08/08/14-08/13/14, the Director of Nursing (DON) provided an in-service to one hundred percent (100%) of the facility's RNs, LPNs and CNAs regarding the results of the survey/review findings. The DON provided additional</li> </ol>	F 309	<p>appropriateness of response and action. The "code" situation of a resident in respiratory distress was conducted by the DON to RN and LPN. Staff responded timely within 1 minute to crisis situation and acted accordingly by obtaining vital signs, assessing the resident and intervening as appropriate and simulating a phone call to the physician. All actions were completed within 3 minutes.</p> <p>Mock codes of similar situations involving patients in respiratory distress will continue weekly, unannounced and varying times and shifts x 6 weeks, then, re-evaluation to determine future frequency. These will be conducted by the DON and RN Team Leader. Codes will be conducted on 7-3, 3-11, 11-7 shifts.</p> <p>100% of all RN and LPN staff were verbally interviewed, one on one, 8/12/14 and 8/13/14 by DON or Regional Nurse to determine their understanding of when and how physician notification is done, in the event of a resident in medical crisis. Verbal "one on one" interviews will continue for the RN and LPN staff with</p>		

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F 309	<p>Continued From page 41</p> <p>in-services to all licensed nurses on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation, which was also completed on 08/13/14. In addition, a Respiratory Therapist provided in-service to all licensed nurses regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse oxygen which was completed on 08/13/14.</p> <p>4. On 08/12/14, the Regional Nurse reviewed the twenty-four (24) hour reports to ensure the physician was notified of all residents with a change of condition from 08/01/14-08/12/14.</p> <p>5. Quality Assurance Monitors began the week of 08/10/14, which included audits of respiratory status/documentation for all residents with respiratory related diagnosis daily, for seven (7) days. In addition, on 08/09/14, the facility began mock "code" situations to evaluate the appropriateness of response and action by facility staff. Additionally, on 08/12/14-08/13/14, the facility verbally interviewed one hundred percent (100%) of all RN and LPN staff regarding when and how to notify the physician in the event of a medical crisis. An additional five (5) weeks of monitoring was added with five (5) interviews per week for five (5) additional weeks. Additional Quality Assurance Monitors included audits to observe the correct oxygen flow, oxygen signs, clean and dated tubing, oxygen tubing off the floor, oxygen saturation monitoring and care plan accuracy which began, on 08/14/14, for one hundred percent (100%) of all residents receiving oxygen therapy by the Regional Nurse.</p> <p>The State Survey Agency validated the Corrective</p>	F 309	<p>5 Interviews per week for 5 weeks to repeat the interviews for all RN and LPN staff, a second time. The interviews will be conducted by the DON. The one (1) licensed nurse on leave was interviewed prior to his/her return to work. The facility does not employ agency/contract staff. The above interviews conducted by the DON for the RN and LPN staff will continue on going as needed, dependent on outcome as advised by the QA committee.</p> <p>A respiratory monitor to observe for correct O2 flow, O2 signs, clean and dated tubing, tubing off the floor, O2 saturation monitoring and care plan accuracy was begun on 8/14/14 for 100% of all residents receiving oxygen therapy by the Regional Nurse. These monitors will continue weekly on 100% of all residents on oxygen therapy. Monitors will be completed by the Respiratory Therapist or Don, and will continue until QA committee deems compliance achieved.</p> <p>Daily rounding and observation of 100% of all residents by the DON/RN team leaders, and charge nurses on all</p>	

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F 309	<p>Continued From page 42</p> <p>Action taken by the facility as follows:</p> <ol style="list-style-type: none"> <li>1. Interview with the Director of Nursing (DON), on 08/20/14 at 2:04 PM, revealed the facility obtained the vital signs of one hundred percent (100%) of all the residents on 08/07/14. Review of the facility's Vital Sign Audit tool revealed one hundred percent of all the residents had his/her vital signs assessed on 08/07/14.</li> <li>2. Review of the facility's Respiratory Assessment Audit Tool revealed that each resident with a respiratory diagnosis or a diagnosis of Congestive Heart Failure received a full respiratory assessment each shift for seven (7) days starting on 08/04/14.</li> </ol> <p>Interview with the RN Team Leader (RN #5), on 08/20/14 at 9:46 AM, the LPN Team Leader (LPN #10), on 08/20/14 at 10:04 AM, and the LPN Team Leader (LPN #1), on 08/20/14 at 10:22 AM, revealed respiratory assessments were completed on their halls daily. They stated the Nurse's Notes were reviewed for accuracy in documentation and the results of the respiratory assessment were also documented on the audit tool for Quality Assurance.</p> <ol style="list-style-type: none"> <li>3. Review, on 08/19/14, of the Inservice logs, dated 08/08/14, 08/09/14, 08/10/14, 08/11/14, and 08/13/14, revealed all staff was inserviced related to emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further review, revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse oxygen</li> </ol>	F 309	<p>shifts provide opportunities for observation that specified care is being provided and resident needs are being met. Additionally, the Medication Administration Records, Treatment Administration Records, 24-hour reports, physician orders, and verbal communications validate systems are in place and the care is being provided for all residents according to care plans for 100% of all residents.</p> <p>All consultant pharmacist recommendations continue to be reviewed to assure compliance with 7 day guidelines, as well as, physician response to recommendations.</p> <p>Pharmacy recommendations will be monitored by the DON for completions weekly until 100% compliance achieved and QA Committee deems appropriate.</p> <p>All Quality Assurance Monitors will be reported to the center's Quality Assurance Committee consisting of the Medical Director, Administrator, Director of Nursing, Medical Records Staff Member, Dietary Manager, Social Worker, Housekeeping Supervisor, and Activities Staff Member. The Director of</p>		

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F 309	Continued From page 43  Interviews with CNA #3, CNA #4, and CNA #2, on 08/20/14 at 9:06 AM, 9:12 AM, and 9:16 AM, respectively, revealed they had received in-servicing regarding the survey results.  Interviews, on 08/19/14, with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM, and on 08/20/14 with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM, LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been in-serviced regarding the survey results. In addition, they stated they also received in-services on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further interview revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse oxygen  Interviews with RN #4 on 08/19/14 at 3:45 PM, and on 08/20/14 with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had received inservicing regarding the survey results. In addition, they stated they also received in-services on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further interview revealed they received an Inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse oxygen  4. Interview with the Regional Nurse Consultant, on 08/20/14 at 12:24 PM, revealed she reviewed the twenty-four hour (24) reports on 08/12/14 to	F 309	Nursing will be responsible to report to the committee. Training and Quality Assurance monitors will continue as directed by the Quality Assurance Committee.	10/3/14	

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F 309	<p>Continued From page 44</p> <p>ensure all residents who were on the 24 hour report, had the appropriate physician notification. Review of the audit reports for the physician notification revealed residents identified with a change of condition received appropriate physician notification.</p> <p>5. Review of facility audits, dated 08/09/14, on all residents with a respiratory diagnosis revealed the residents received daily assessments for seven (7) days to include assessments of mentation, vital signs, oxygen saturation, skin color and temperature, oxygen device and flow rate, quality of respirations and lung sounds, presence of chest pain or cough and for the presence of any additional subjective complaints.</p> <p>Review of the facility's audit reports, dated 08/14/14, revealed the facility conducted audits regarding residents who were receiving oxygen to observe for the correct oxygen flow, oxygen door signs, clean and dated tubing, oxygen tubing off the floor, oxygen saturation monitoring and care plan accuracy, beginning on 08/14/14, for one hundred percent (100%) of all residents receiving oxygen therapy by the Regional Nurse.</p> <p>Interview with the Regional Nurse Consultant, on 08/20/14 at 12:24 PM, revealed she performed an audit on all residents receiving oxygen to observe for the correct oxygen flow, appropriate placement of oxygen signs, clean and dated oxygen tubing, observed for oxygen tubing off the floor, oxygen saturation monitoring and the care plan was accurate and appropriate for all residents receiving oxygen.</p> <p>Interviews on 08/19/14, with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM, and</p>	F 309			

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F 309	Continued From page 45 interviews on 08/20/14 with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM, LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the LPNs revealed the Director of Nursing(DON) was conducting random mock "code" situations to monitor and evaluate the appropriateness of response and action by the facility's licensed staff.  Interviews with RN #4 on 08/19/14 at 3:45 PM, and on 08/20/14 with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the RN staff revealed the Director of Nursing (DON) was conducting random mock "code" situations to monitor and evaluate the appropriateness of response and action by the facility licensed staff.	F 309			
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on Interview, record review, review of the facility's policy and procedure, and review of the	F 323	F-323 Begins on next page		

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F 323	<p>Continued From page 48</p> <p>Hospital History and Physical, Hospital Emergency Room Note it was determined the facility failed to provide adequate supervision to prevent accidents for two (2) of nine (9) sampled residents (Resident #1 and Resident #2).</p> <p>Resident #2 was re-admitted to the facility on 04/08/14 from a psychiatric hospitalization with new orders for an antipsychotic medication, Haldol five (5) milligrams (mg) twice a day. On 06/03/14, the Consultant Pharmacist, during the monthly medication regimen review recommended a trial dose reduction of Haldol from five (5) mg to two and one half (2.5 mg). On 06/12/14, Resident #2 had a fall with injury and was noted at the time of the fall, to have a shuffling gait, which was a side effect of the Haldol. Resident #2 was diagnosed with a non-displaced fracture to his/her left clavicle (collarbone). The physician was notified of the shuffling gait; however, was not notified of the Consultant Pharmacist's recommendation. The physician ordered Cogentin, a medication to help reduce the side effects of the antipsychotic medication, Haldol. Resident #2 had a second fall three (3) days later on 06/15/14 resulting in three (3) additional fractures (his/her humerus, radius, and ulna). The physician was not made aware of the recommendation until 06/17/14, after the resident had sustained two (2) falls with injury.</p> <p>On 07/01/14, the facility assessed Resident #1 as dependent on two (2) staff for transfers; however, review of the care plan revealed an Intervention for one (1) to two (2) staff to transfer. On 07/25/14, Resident #1 was lowered to the floor during a transfer when he/she was being transferred by one (1) Certified Nursing Assistant (CNA). Resident #1 sustained a fracture of the</p>	F 323	<p>F323</p> <ul style="list-style-type: none"> <li>Resident #1 expired on 8/1/14. No action was able to be taken to correct the deficient practice. Resident #2 expired on 7/4/14. No action was able to be taken to correct this deficient practice.</li> <li>All residents who fell in facility from 7/1/14 through 8/1/14 (and on-going) have had both their care plans and pharmacy recommendations reviewed by DON and RN/LPN Team Leaders to assure all care plans were up to date with correct interventions. The care plans of all residents who fell were up to date with correct intervention.</li> </ul> <p>A 100% audit of all residents who have returned to the facility post hospitalization beginning with 7/1/14 was completed by RN MDS Coordinators on 8/14/14 to ensure care needs are reflected in the care plan accurately. Care plans for post hospitalization residents were updated as needed based on individual care needs by the RN MDS Coordinators.</p>		

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F 323	<p>Continued From page 47</p> <p>right fibula (leg bone) after the fall. The resident was assessed as having a significant decline in ADLs and expired at the facility on 07/04/14.</p> <p>The facility's failure to provide adequate supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/23/14 and was determined to exist on 06/15/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedures titled "Accidents and Incident Investigations" not dated, revealed that when an accident occurs, the staff are to identify the activity and cause of the fall, perform a review of the resident's medication, update the care plan and ensure all appropriate parties are notified.</p> <p>1. Record review revealed the facility admitted Resident #1 on 10/24/13 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Chronic Kidney Disease, and Hypertension.</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment, dated 05/08/14, revealed the facility assessed the resident as requiring the extensive physical assistance of two (2) plus persons for transfers. In addition, review of an Admission Nursing Assessment conducted on 07/01/14, revealed Resident #1 was totally dependent on two (2) plus staff for transfers. However, review of the Comprehensive Care Plan, dated 05/20/14, revealed an intervention to provide the assistance of one (1) to two (2) staff with transfers.</p>	F 323	<p>100% of all residents have had their care plans reviewed and updated as needed by the DON, RN/LPN team leaders, and RN MDS Coordinators. The updates were completed by the DON, RN/LPN team leaders, and RN MDS Coordinators on 8/15/14. A recap of 100% of all resident's current physician orders including nursing tasks, fall interventions, treatments, code status, therapy orders, diet orders, adaptive equipment, and labs were printed and these were compared to the current care plan to ensure that the interventions listed on physician orders were included in the care plan.</p> <p>A review of 100% of all consultant pharmacy recommendations was completed on 8/28/14 going back to 7/1/14 by the DON and RN/LPN Team Leaders. All recommendations were acted upon within 14 days of writing, as was the policy/practice of that time. Any recommendations resulting in a change to resident's plan of care was added to the resident's care plan.</p> <ul style="list-style-type: none"> <li>• Upon instruction of the administrator, in-service training was</li> </ul>	

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F 323	<p>Continued From page 48</p> <p>Review of a Post Falls Nursing Assessment, dated 07/14/14, revealed one CNA was transferring Resident #1 from the bed to the chair on 07/12/14 at 9:30 AM, when the resident had to be lowered to the floor. There were no injuries identified at the time. However, review of a Hospital History and Physical, dated 07/13/14, revealed Resident #1 complained of right ankle pain and shortness of breath when he/she arrived at the hospital. An x-ray was conducted which revealed a displaced spiral fracture of the distal fibula.</p> <p>Interview with CNA #2, on 07/29/14 at 1:16 PM, revealed she was the primary aide for Resident #1 most of the time. She stated the resident had gotten weaker since his/her most recent hospitalization. CNA #2 stated, "Now I am doing everything for the resident because he/she just can't do it." She revealed she was no longer able to get the resident up to use the bedside commode per the care plan. She stated, "I just put the resident on the bed pan."</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 07/31/14 at 1:11 PM, revealed she was the nurse on duty at the time of Resident #1's fall. She stated she was called to the room by a CNA to assist with getting the resident back in bed which required several people to get him/her back in bed. She stated she assessed the resident and did not identify any injuries and the resident had no complaints of pain. LPN #2 stated at approximately 8:45 PM, she went to administer Resident #1's medication and the resident was "kind of shaky" and had decreased alertness. She stated the resident's oxygen saturation was eighty-four percent (84%) and the resident had no</p>	F 323	<p>conducted beginning 8/8/14 by the DON. The training included the following topics: Updating care plan problems based on resident condition/changes, updating care plan interventions as new order/changes occur, updating care plans upon return from the hospital, and updating CNA care plans with any changes on the medical record care plan. All RN's and LPN's on staff received training. In-service training was completed on 8/12/14. One (1) licensed nurse was on leave at time with in-servicing being conducted by phone by the DON on 8/12/14.</p> <p>One newly hired RN was Inserviced on the aforementioned topics prior to assuming duties by the Team Leader. The facility does not employ agency/contract staff.</p> <p>100% of all CNA's were in-serviced by the DON and RN/LPN team leaders beginning on 8/8/14 on care plan location and CNA responsibility to review information for updates on care plans. Those CNAs not in attendance were contacted by phone by the DON, RN/LPN team leaders, or RN MDS</p>	

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F 323	<p>Continued From page 49</p> <p>complaints of pain. LPN #2 stated she phoned the physician and sent the resident to the Emergency Room (ER) via ambulance.</p> <p>Interview with Registered Nurse (RN) #2, on 07/30/14 at 3:38 PM, revealed she was the nurse who completed the re-admission assessment for Resident #1. She stated the resident required a lot of care due to the Congestive Heart Failure and Chronic Pulmonary Disease. RN #2 stated Resident #1 had chronic pain and fluid overload. RN #2 stated the resident had been able to transfer and ambulate with the assistance of one (1) staff member before his/her hospitalization and she thought the CNAs would get two (2) staff if it was needed, therefore she did not update the Comprehensive Care Plan to ensure adequate supervision was provided.</p> <p>Interview with RN #3, MDS Coordinator, on 07/30/14 at 9:43 AM, revealed when a resident was readmitted to the facility from the hospital, the nurse completing the re-admission assessment would update the care plan based on any necessary changes and if an MDS was done, it would be reviewed at that time. She stated the care plan should be based on the resident's current conditions and diagnoses</p> <p>2. Record review revealed the facility readmitted Resident #2 on on 04/08/14 with diagnoses which included Senile Dementia, Hallucinations, Adjustment Disorder with Anxiety, Diabetes Mellitus and Hypertension.</p> <p>Review of a Significant Change MDS assessment, dated 04/17/14, revealed the facility assessed the resident to require supervision only with transfers and ambulation.</p>	F 323	<p>Coordinators on 8/13/14. All CNAs verbally verified their understanding of in-servicing to the DON, RN/LPN team leaders, or RN MDS Coordinators.</p> <p>Certified Occupational Therapy Assistant conducted a hands on training with CNAs on 8/9/14 and 8/11/14 to review transfer techniques and accuracy of care plans as related to level of care provided (for transfers).</p> <p>The review process of falls/accidents has been revised. Falls team, consisting of DON, COTA, Rn and Lpn Team Leaders meets post-fall daily, Monday through Friday, to review resident's nursing notes, medications, care plan, staff statements, and details regarding falls and cross checks with any pharmacy recommendations within the last 30 days.</p> <p>Newly admitted residents are screened upon admission by therapy department staff for appropriate level of transfer assistance.</p> <p>Accidents are audited daily Monday through Friday by the DON to ensure accuracy of incident reporting and</p>		

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F 323	<p>Continued From page 50</p> <p>Review of Resident #2's Comprehensive Care Plan, dated 04/22/14, revealed Resident #2 was at risk for falls related to impaired balance during transitions and walking, and the use of multiple psychoactive medications. Interventions included to observe for unsafe actions such as unassisted transfers and intervene as needed.</p> <p>Review of a Post Falls Nursing Assessment and Falls Investigation Summary, dated 08/13/14, revealed Resident #2 had a fall on 06/12/14, and at the time of the fall the resident was observed shuffling his/her feet which caused him/her to fall. The resident was assessed immediately after the fall and it was noted that the resident had complaints of pain, rating the pain as an eight (8) out of ten (10) on the pain rating scale. The resident also had a two (2) centimeter laceration above his/her left eyebrow area with bruising and swelling. The resident's left eye was cleaned with normal saline and the resident was given a cold pack to the left eyebrow area.</p> <p>Review of the Comprehensive Care Plan, updated 06/12/14, revealed a referral screen for therapy related to shuffling gait and Cogentin, as ordered.</p> <p>Review of a Physician's Order, dated 06/12/14, revealed a new order for an x-ray of the left orbital facial bones, left complete shoulder, and left knee due to recent fall with pain and swelling. Review of the Post Falls Investigation, dated 06/13/14, revealed a Physician's Order was received for Cogentin to help reduce the side effects of the Haldol.</p> <p>Further review of a Physician's Note, dated</p>	F 323	<p>appropriateness of follow through with interventions and care planning utilizing a falls follow-up checklist.</p> <p>Antipsychotic use is reviewed by the consultant pharmacist on-going monthly, to monitor for appropriateness, diagnosis, dosage, gradual dose reduction and provide recommendations as indicated. The pharmacy recommendations process was revised as follows:</p> <ol style="list-style-type: none"> <li>1. The consultant pharmacist will print recommendations prior to exiting the facility.</li> <li>2. Recommendations will be given to the DON or in the DON's absence, to the Administrator.</li> <li>3. The DON will distribute copies of the recommendations to the appropriate Team Leader by the next business day.</li> <li>4. The RN/LPN Team Leader will contact the attending physician to obtain a response to the recommendation. Recommendations will be returned to the DON with seven (7) days of receipt of the recommendation.</li> </ol>		

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F 323	<p>Continued From page 51</p> <p>06/19/14, revealed the resident sustained a fractured left clavicle when he/she fell on 06/13/14 and new orders were received for a butterfly sling.</p> <p>Review of a Post Falls Investigation, dated 08/17/14, revealed the resident had an unwitnessed fall on 08/15/14 at approximately 3:45 AM, when he/she was ambulating in the hall unsupervised. Resident #2 was assessed immediately after the fall and noted the resident to have complaints of pain to his/her right arm, rating the pain as a ten (10) out of ten (10) on the pain scale.</p> <p>Review of a Nurse's Note, dated 06/15/14 at 4:00 AM, revealed Resident #2 continued to complain of pain in his/her arm and stated he/she was unable to move his/her arm. Further review revealed the physician was notified and Resident #2 was sent to the Emergency Room.</p> <p>Review of a Hospital Emergency Room Note, dated 06/15/14, revealed Resident #2 received x-rays of his/her arm and was diagnosed with a fractured humerus, fractured radius, and fractured ulna. Further review revealed the resident received a splint to his/her right wrist and a sling for his/her right arm and was discharged back to the facility on 06/15/14.</p> <p>Review of a Significant Change MDS Assessment, dated 08/20/14, revealed the facility had assessed Resident #2 as having severe cognitive impairment, and was rarely or never understood and unable to complete the Mental Status Assessment. In addition, the facility had assessed Resident #2 to require extensive, two (2) plus persons physical assist with bed mobility,</p>	F 323	<p>5. The DON will track and monitor recommendations to assure a timely response and follow up to the recommendations.</p> <p>The revised practice was revealed with the team leaders on 8/8/14 and instituted. The physicians will no longer be notified by placing the recommendation in their communication folder.</p> <p>Review of all consultant pharmacist recommendations continue to be performed to assure compliance with in 7 days response guidelines, as well as, physician response to recommendations. Pharmacy recommendations will be monitored by the DON for completion weekly until 100% compliance achieved and QA committee deems appropriate.</p> <ul style="list-style-type: none"> <li>On August 11, 2014, The Regional Nurse reviewed with the Director of Nursing the Quality Assurance Monitors that began on August 11, 2014. Monitors reviewed include:</li> </ul> <p>100% of all RN and LPN staff were verbally interviewed, one on one,</p>		

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F 323	<p>Continued From page 52 transfer and ambulation.</p> <p>Review of a Consultant Pharmacy Recommendation, dated 06/03/14, revealed a recommendation for the physician to consider a trial dose reduction of Haldol (an antipsychotic medication), as there was no documented evidence of the resident exhibiting behaviors for the use of the medication. The Haldol was to be decreased from five (5) to two and a half milligram (2.5 mg) twice a day. Review of a Physician's Order, dated 06/17/14, revealed the physician did not address the pharmacy recommendations until 06/17/14, fourteen (14) days after the recommendation was made by the Pharmacist.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 07/30/14 at 2:22 PM, revealed she phoned the physician to inform him of the resident's fall and noted shuffling gait (side effect of Haldol). The ADON stated she was not sure if the physician was aware of the Pharmacy Consultant's recommendation when she phoned to report the fall related to the shuffling gait. She stated she reported the shuffling gait, and he ordered Cogentin for the side effects of Haldol.</p> <p>Interview with the Director of Nursing (DON), on 08/07/14 at 3:37 PM, revealed the ADON and the Team Leaders work with the pharmacy recommendations to ensure they were addressed by the physician. She stated ultimately it was the DON's responsibility to make sure the pharmacy recommendations were addressed. She stated she was not sure how this was overlooked. Further interview revealed the physician should have been made aware of the Consultant Pharmacist's recommendations (06/03/14) at the</p>	F 323	<p>8/12/14 and 8/13/14 by DON or Regional Nurse to determine their understanding of when and how physician notification is done, in the event of a resident in medical crisis.</p> <p>Verbal "one on one" interviews will continue for the RN and LPN staff with 5 interviews per week for 5 weeks to repeat the interviews for all RN and LPN staff, a second time. The interviews will be conducted by the DON. The one (1) licensed nurse on leave was interviewed prior to his/her return to work. The facility does not employ agency/contract staff.</p> <p>Daily, 100% of all newly written physician orders and telephone orders will be reviewed by the RN/LPN team leaders to ensure all residents who have received any physician orders have had their care plans reviewed and updated. Monitoring will be conducted by the DON on-going weekly x 5 weeks until the Quality Assurance Committee determines compliance. This began on 8/12/14 and will continue.</p> <p>CNAs will be interviewed by RN/LPN team leaders 12 per week x 5 weeks to</p>		

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F 323	<p>Continued From page 53</p> <p>time of the first fall (08/12/14). Further interview revealed Resident #1 did not receive a therapy evaluation at that time and the order was put on hold related to the new diagnosis of fractured clavicle pending clearance from the orthopedic specialist. Additionally, the DON stated, "The care plan was not updated related to the falls, and it should have been."</p> <p>Interview with the Administrator, on 08/07/14 at 4:14 PM, revealed the physician should have been made aware of the Pharmacist's recommendations at the time of the first fall.</p> <p>Interview with the Consultant Pharmacist, on 08/01/14 at 1:04 PM, revealed the side effects of the Haldol could include a shuffling gait, abnormal movements and gait disturbance. Further interview revealed the side effects of Haldol were generally abrupt in nature but could develop at any time. She stated Cogentin was used to control the side effects of the Haldol. Further interview revealed if side effects developed the appropriate thing to do was to ask for a reduction. She stated, "If the physician had agreed to the trial dose reduction at the time of recommendation, it is possible the fall could have been avoided."</p> <p>Interview with Resident #2's Physician, on 08/01/14 at 9:12 AM, revealed he did not know if he was aware Resident #2 had a shuffling gait at the time of his/her fall. Additionally, he stated that he did not recall being made aware of the Consultant Pharmacist's recommendations (06/03/14) at the time of Resident # 2's fall on 06/12/14. Additionally, he stated he ordered the medication, Cogentin when he was made aware of the shuffling gait.</p>	F 323	<p>ensure their understanding of care plans. By the end of the 5 weeks, all CNAs will have been interviewed a second time to ensure their continued understanding of care plans. The RN/LPN team leaders will conduct the interviews on-going until the QA committee determines compliance.</p> <p>Daily rounding and observations on 100% of all residents by the DON, RN/LPN team leaders and charge nurses provide opportunities for observation that specified care is being provided and resident needs are being met. Additionally, the Medication Administration Records, Treatment Administration Records, 24-hour reports, physician orders, and verbal communications validate systems are in place that the care is being provided for all residents according to care plans for 100% of all residents.</p> <p>All Quality Assurance Monitors will be reported to the center's Quality Assurance Committee consisting of the Medical Director, Administrator, Director of Nursing, Medical Records Director, Dietary Manager, Social Worker, Housekeeping Supervisor, and</p>		

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F 323	Continued From page 54  **The facility implemented the following actions to remove the Immediate Jeopardy:  1. On 08/26/14 through 08/28/14 the DON and RN/LPN Team Leaders audited the investigations of 100% of eighteen (18) residents that fell from 07/01/14 through 08/01/14 to ensure that previous investigation of the falls were appropriate.  2. On 08/15/14 the DON, RN/LPN Team Leaders and RN MDS Coordinator reviewed 100% of the care plans to ensure current physician orders, treatments, code status, diet orders, fall interventions, nursing tasks, therapy orders, adaptive equipment, and labs were included on the care plan.  3. On 08/05/14, the DON revised the falls review process which included daily meetings Monday through Friday to review the nursing notes, medications, care plan, staff statements, and details regarding the falls of any resident who had a fall. In addition, the falls team cross checks the pharmacy recommendations within the proceeding thirty (30) days. Additionally, any falls that occur after hours or on the weekend the DON or ADON is notified prior to the end of the shift to ensure appropriate interventions and actions were taken.  4. Beginning on 08/20/14, the CNAs will be interviewed by the RN/LPN team leaders, twelve (12) per week for five (5) weeks to ensure there understanding of the care plans.  5. All QA monitors will be reported to the QA Committee and will continue as directed by the	F 323	Activites Director. The Director of Nursing will be responsible to report to the committee. Training and Quality Assurance monitors will continue as directed by the Quality Assurance Committee.	10/3/14	

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F 323	<p>Continued From page 55 QA Committee and Regional Nurse.</p> <p>The State Survey Agency validated the Corrective Action taken by the facility as follows:</p> <p>1. Interview with the DON on 09/25/14 at 1:06 PM revealed she along with the RN/LPN Team Leaders audited the investigations of 100% of eighteen (18) residents that fell from 07/01/14 through 08/01/14 to ensure that previous investigation of the falls were appropriate.</p> <p>Interview with Team Leader (RN #5) on 09/25/14 at 9:51 AM revealed she audited the investigations of 100% of eighteen (18) residents that fell from 07/01/14 through 08/01/14 to ensure that previous investigation of the falls were appropriate.</p> <p>Interview with the Team Leader (LPN #1) on 09/25/14 at 10:27 AM revealed she audited the investigations of 100% of eighteen (18) residents that fell from 07/01/14 through 08/01/14 to ensure that previous investigation of the falls were appropriate.</p> <p>2. Interview with the DON on 09/25/14 at 1:06 PM revealed she reviewed 100% of the care plans to ensure current physician orders, treatments, code status, diet orders, fall interventions, nursing tasks, therapy orders, adaptive equipment, and labs were included on the care plan.</p> <p>Interview with Team Leader (RN # 5) on 09/25/14 at 9:51 AM revealed she audited 100% of the care plans to ensure current physician orders, treatments, code status, diet orders, fall interventions, nursing tasks, therapy orders, adaptive equipment, and labs were included on</p>	F 323		

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F 323	<p>Continued From page 58 the care plan.</p> <p>Interview with Team Leader (LPN # 1) on 09/25/14 at 10:27 AM, revealed she audited 100% of the care plans to ensure current physician orders, treatments, code status, diet orders, fall interventions, nursing tasks, therapy orders, adaptive equipment, and labs were included on the care plan.</p> <p>3. Interview with the DON on 09/25/14 at 1:06 PM revealed she revised the falls review process which included daily meetings Monday through Friday to review the nursing notes, medications, care plan, staff statements, and details regarding the falls of any resident who had a fall. In addition, she stated the falls team cross checks the pharmacy recommendations within the proceeding thirty (30) days. Additionally, any falls that occur after hours or on the weekend the DON or ADON is notified prior to the end of the shift to ensure appropriate interventions and actions taken.</p> <p>4. Interview on 09/24/14 with CNA #6 at 4:18 PM, CNA #7 at 4:20 PM, CNA #8 at 4:22 PM and CNA #9 at 4:25 PM, revealed they were interviewed by the RN/LPN Team Leaders related to the location and interventions on the residents care plans.</p> <p>5. Interview with the Activities Director on 09/25/14 at 12:37 PM revealed she is a member of the QA Committee and has been informed of the progress and results of the audit tool and monitors in place at the facility.</p> <p>Interview with the Licensed Social Worker (LSW) on 09/25/14 at 12:42 PM revealed she is a member of the QA Committee and has been</p>	F 323			

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F 323	Continued From page 57	F 323			
F 428 SS=J	<p>informed of the progress and results of the audit tools and monitors in place at the facility.</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to ensure the pharmacist's recommendation for a gradual dose reduction was reported to the attending physician in order for the reports to be acted upon for one (1) of nine (9) sampled residents (Resident #2).</p> <p>Resident #2 was re-admitted to the facility on 04/08/14 from a psychiatric hospitalization with a new order for Haldol (antipsychotic) five (5) milligrams (mg) twice a day. On 06/03/14, the Consultant Pharmacist performed the monthly medication regimen review and recommended a trial dose reduction of the Haldol from five (5) mg to two and one half (2.5 mg), two (2) times daily; however, the facility failed to ensure the physician was made aware of the report and that it was acted upon. On 06/12/14 at approximately 4:00</p>	F 428	<p>F428</p> <ul style="list-style-type: none"> <li>Resident #2 expired on 7/4/14. No action was able to be taken to correct the deficient practice.</li> <li>The consultant pharmacist reviewed the medical record of all patients on antipsychotic medications to assure appropriate diagnosis, dosages, duration, required lab work and gradual dose reduction on 8/8/14 and 09/22/14.</li> </ul> <p>No patients were found to be on any antipsychotic medication outside accepted parameters as described on BEERS criteria list.</p> <p>A review of 100% of all consultant pharmacy recommendations was completed on 8/28/14 going back to 7/1/14. All recommendations were acted upon within 14 days of writing, as was the policy/practice at that time. No other residents were affected by the deficient practice.</p> <ul style="list-style-type: none"> <li>On 8/8/14 the DON met with the consultant pharmacist to review the</li> </ul>		

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F 428	<p>Continued From page 58</p> <p>PM, approximately nine (9) days after the recommendation was made, Resident #2 had a fall which resulted in a fracture to his/her left clavicle (collarbone). Resident #2 was noted to have a shuffling gait which was a side effect of the antipsychotic medication. The physician was made aware of the shuffling gait but the facility failed to make the physician aware of the Consultant's recommendation. The physician ordered Cogentin to help reduce the side effects of the Haldol.</p> <p>Resident #2 had a second fall three (3) days later on 08/15/14, which resulted in fractures of the resident's humerus, radius, and ulna (arm); the physician was still not made aware of the Consultant's recommendation to consider a trial dose reduction. The physician was not notified of the pharmacy recommendations until 08/17/14, approximately fourteen (14) days after the recommendation. The physician reduced the Haldol dosage to two (2) milligrams (mg) twice a day. The physician visited the resident on 08/19/14 and discontinued the Haldol and Cogentin due to the resident having the two (2) significant falls and noting the resident was markedly lethargic.</p> <p>The facility's failure to notify the physician of the pharmacy recommendation for the gradual dose reduction of the antipsychotic medication has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/23/14 and was determined to exist on 08/15/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled,</p>	F 428	<p>correct practice of pharmacy recommendation review. The following guidelines were agreed upon by the consultant pharmacist, Director of Nursing, Medical Director and Administrator.</p> <ol style="list-style-type: none"> <li>1. The consultant pharmacy will print recommendations prior to exiting the facility.</li> <li>2. Recommendations will be given to the DON or in the DON's absence, to the Administrator.</li> <li>3. The DON will distribute copies of the recommendations to the appropriate RN/LPN Team Leader by the next business day.</li> <li>4. The RN/LPN Team Leader will contact the attending physician to obtain a response to the recommendation. Recommendations will be returned to the DON with seven (7) days of receipt of the recommendation.</li> <li>5. The DON will track and monitor recommendations to assure a timely response and</li> </ol>	

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F 428	<p>Continued From page 59</p> <p>"Consultant Pharmacist Reports", dated 10/2011, revealed the consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendations regarding residents' medication therapy are communicated to those with authority and /or responsibility to implement the recommendations, and respond in an appropriate and timely fashion. Further review revealed the Consultant Pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for the prescriber and/or nursing review. Additionally, review of the policy revealed the comments and recommendations concerning medication therapy were to be communicated in a timely fashion.</p> <p>Review of the facility's policy and procedures titled, "Medication Monitoring and Management", dated 10/2011, revealed when a resident's clinical condition had improved or stabilized, the underlying causes of the original target symptoms had resolved, and/or non-pharmacological interventions, including behavioral interventions, had been effective in reducing the symptoms, the resident would be evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication.</p> <p>Record review revealed the facility admitted Resident #2 on 01/28/14; and re-admitted him/her on 04/08/14 with diagnoses which included Senile Dementia, Hallucinations, Adjustment Disorder with Anxiety, Diabetes Mellitus, and Hypertension.</p> <p>Review of the readmission orders, dated 04/08/14, revealed Resident #2 had orders for Haldol five (5) mg twice a day.</p>	F 428	<p>follow up to the recommendations.</p> <p>The revised practice was reviewed with the RN/LPN team leaders on 8/8/14 and instituted. The physicians will no longer be notified by placing the recommendation in their communication folder.</p> <ul style="list-style-type: none"> <li>Review of all consultant pharmacist recommendations continue to be performed to assure compliance with in 7 days response guidelines, as well as, physician response to recommendations. Pharmacy recommendations will be monitored by the DON for completion weekly until 100% compliance achieved and QA committee deems appropriate.</li> </ul> <p>The consultant pharmacist will continue to conduct monthly medication reviews of all patients on antipsychotic medications and make recommendations as deemed necessary. These reviews will be evaluated for compliance with recommendations by the DON. The medication review will be continued monthly as required by regulation and</p>		

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F 428	<p>Continued From page 60</p> <p>Review of Resident #2's Behavior Flow Record, dated 05/2014, revealed Resident #2 was monitored for throwing objects, hitting staff, and paranoid behavior. Staff was to evaluate the effectiveness of the antipsychotic medication Haldol. Further review revealed no behaviors were reported during that time.</p> <p>Review of a Pharmacy Recommendation, dated 06/03/14, revealed a recommendation for the physician to consider a trial dose reduction of Haldol. The Haldol was to be decreased from five (5) to two and a half milligram (2.5 mg) twice a day. Review of a Physician's Order, dated 06/17/14, revealed the physician did not address the pharmacy recommendations until 06/17/14, fourteen (14) days after the recommendation was made. The Haldol was decreased to two (2) milligrams.</p> <p>Review of a Falls Investigation Summary, dated 08/13/14, revealed Resident #2 had a fall on 08/12/14 and at the time of the fall the resident was observed shuffling his/her feet which caused him/her to fall. The physician was made aware of the shuffling gait and ordered Cogentin to help reduce the side effects of the Haldol. Further review revealed, the resident was assessed immediately after the fall and noted to have complaints of pain, rating the pain as an eight (8) out of ten (10) on the pain rating scale. Further review of the Summary revealed the resident had a two (2) centimeter laceration above his/her left eyebrow area with bruising and swelling. The resident's left eye was cleansed with normal saline and the resident was given a cold pack to apply to his/her left eyebrow area.</p>	F 428	<p>the audit of compliance with recommendation will continue until the QA committee deems compliance is achieved and maintained. In addition, the consultant pharmacist provided an in-service to RN and LPN staff regarding AIMS testing and EPS symptoms on 09/25/14.</p> <p>All Quality Assurance Monitors will be reported to the center's Quality Assurance Committee consisting of the Medical Director, Administrator, Director of Nursing, Medical Records Staff Member, Dietary Manager, Social Worker, Housekeeping Supervisor, and Activities Director. The Director of Nursing will be responsible to report to the committee. Training and Quality Assurance monitors will continue as directed by the Quality Assurance Committee.</p>	10/3/14	

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F 428	<p>Continued From page 61</p> <p>Review of a Physician's Order, dated 06/12/14, revealed a new order for an x-ray of the left orbital facial bones, left complete shoulder, and left knee due to recent fall with pain and swelling. Further review of the Post Falls Investigation, dated 06/13/14, revealed a Physician's Order was received for Cogentin to help reduce the side effects of the Haldol.</p> <p>Review of a Physician's Note, dated 06/19/14, revealed Resident sustained a fractured left clavicle when he/she fell on 06/13/14 and new orders were written for a butterfly sling</p> <p>Review of a Post Falls Investigation, dated 06/17/14, revealed the resident had an unwitnessed fall on 06/15/14 at approximately 3:45 AM, when he/she was ambulating in the hall unsupervised. Resident #2 was assessed immediately after the fall and had complaints of pain to his/her right arm, rating the pain as a ten (10) out of ten (10) on the pain scale.</p> <p>Review of a Nurse's Note, dated 06/15/14 at 4:00 AM, revealed Resident #2 continued to complain of pain in his/her arm and stated he/she was unable to move his/her arm. Further review revealed the physician was notified and Resident #2 was sent to the Emergency Room.</p> <p>Review of a Hospital Emergency Room Note, dated 06/15/14, revealed Resident #2 received x-rays of his/her arm and was diagnosed with a fractured humerus, fractured radius, and fractured ulna. Further review revealed the resident received a splint to his/her right wrist and a sling for his/her right arm and was discharged back to the facility on 06/15/14. The physician ordered for the facility to follow up with an</p>	F 428			

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F 428	<p>Continued From page 62</p> <p>Orthopedic Surgeon in three (3) days.</p> <p>Interview with the Consultant Pharmacist, on 08/06/14 at 4:56 PM, revealed she performed medication regimen reviews at least monthly at the facility. She stated after she completed the pharmacy review, she would print the pharmacy recommendations and give them to the DON or the ADON. She stated they were hand delivered or placed in their mailboxes. She revealed she visits the facility monthly and each month she tracks the month before to ensure all recommendations were addressed and received a follow up. She stated if she finds a recommendation that has not been responded to she will reprint and alert the DON/ADON.</p> <p>Interview with the ADON, on 07/30/14 at 2:22 PM; and, on 08/05/14 at 9:00 AM, revealed the Consultant Pharmacist performs medication regimen reviews on each resident at least monthly. The ADON stated, "Once the reviews were completed, the Pharmacy Consultant would print the recommendations, and give them to us [DON/ADON] to follow up on." The ADON stated, "Once I receive the recommendations, I would phone the physician and make him aware of the recommendations received." The ADON revealed sometimes the physician would give an immediate verbal order and sometimes the physician would wait until he was at the facility to make rounds at least once a week. The ADON stated, "I do not know how the recommendation slipped through the cracks."</p> <p>Interview with the DON, on 08/07/14 at 3:37 PM, revealed the ADON and the Team Leaders work with the pharmacy's recommendations to ensure they were addressed by the physicians. She</p>	F 428			

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F 428	<p>Continued From page 63</p> <p>stated ultimately it was the her (DON's) responsibility to make sure the pharmacy recommendations were addressed. She stated she was not sure how this was overlooked. She stated when the Pharmacy Consultant completed the reviews, the Pharmacy Consultant printed the recommendations and gave them to the DON or the ADON for follow-up.</p> <p>Interview with Resident #2's Physician, on 08/01/14 at 9:12 AM, revealed he did not recall being made aware of the Pharmacy Consultant's Recommendation at the time of Resident #2's fall on 06/12/14.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. On 08/08/14 the Consultant Pharmacist reviewed the medical record of 100% of all patients on antipsychotic medications to assure diagnosis, dosages, duration, required lab work and gradual dose reduction were appropriate.</li> <li>2. On 08/28/14 the DON and RN/LPN Team Leaders reviewed 100% of the pharmacy recommendations for 07/2014 to ensure they were acted upon within fourteen (14) days of writing, per the policy and procedure.</li> <li>3. On 08/08/14 the DON met with the Consultant Pharmacist to review the correct practice of pharmacy recommendation review and the DON was trained by the Consultant Pharmacist on the revised practice and the DON trained the RN/LPN Team Leaders.</li> <li>4. Review of the Consultant Pharmacist recommendations continue to be performed to</li> </ol>	F 428			

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F 428	<p>Continued From page 64</p> <p>assure compliance with-in a seven (7) day response guidelines, and the physician response to recommendations. In addition, the pharmacy recommendations will be monitored by the DON for completion weekly until 100 % compliance achieved and Quality Assurance (QA) Committee deems appropriate.</p> <p>5. The Consultant Pharmacist will continue to conduct monthly medication reviews of all residents on antipsychotic medications and make recommendations as deemed necessary. These reviews will be evaluated for compliance with recommendations by the DON. The medication review will be continued monthly as required by regulation and the audit of compliance with recommendation will continue until the QA Committee deems compliance is achieved and maintained.</p> <p>6. All QA monitors will be reported to the QA Committee and will continue as directed by the QA Committee and Regional Nurse.</p> <p>The State Survey Agency validated the Corrective Action taken by the facility as follows:</p> <p>1. Interview with the Consultant Pharmacist on 09/25/14 at 10:07 AM, revealed she reviewed the medical record of 100% of all patients 08/08/14 who were on antipsychotic medications to assure diagnosis, dosages, duration, required lab work and gradual dose reduction were appropriate.</p> <p>Review of the facility's Pharmacy Anti-Psychotic Drug Audit dated 08/2014 and 09/2014 revealed 100% of all residents had a medication regimen review completed by the Consultant Pharmacy.</p>	F 428			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/25/2014
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
(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 428	<p>Continued From page 65</p> <p>2. Interview with the DON on 09/25/14 at 1:01 PM revealed she reviewed 100% of the pharmacy recommendations for 07/2014 to ensure they were acted upon within fourteen (14) days of writing, per the policy and procedure.</p> <p>Interview with Team Leader (RN #5) on 09/25/14 at 9:55 AM, revealed she reviewed 100% of the pharmacy recommendations to ensure they were acted upon within fourteen (14) days of writing, per the policy and procedure.</p> <p>Interview with Team Leader (LPN #1) on 09/25/14 at 10:35 AM, revealed she reviewed 100% of the pharmacy recommendations to ensure they were acted upon within fourteen (14) days of writing, per the policy and procedure.</p> <p>Review of the facility's Pharmacy Recommendation Audit dated 07/2014, 08/2014, and 09/2014, revealed that 100% of all residents with pharmacy recommendations had the recommendations acted upon within fourteen (14) days.</p> <p>3. Interview with the Consultant Pharmacist on 09/25/14 at 10:07 AM, revealed she met with the DON on 08/08/14 to review the correct practice of pharmacy recommendation and to train the DON on the newly revised practice.</p> <p>Interview with Team Leader (RN #5) on 09/25/14 at 9:55 AM, revealed she received training from the DON regarding the correct practice of pharmacy recommendations.</p> <p>Interview with Team Leader (LPN #1) on 09/25/14 at 10:35 AM, revealed she received training from the DON regarding the correct practice of</p>	F 428			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/25/2014
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
(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 428	<p>Continued From page 66 pharmacy recommendations.</p> <p>Review of a facility inservice dated 08/08/14, revealed the RN/LPN Team Leaders were inserviced regarding the correct practice of pharmacy recommendations.</p> <p>4. Interview with the DON on 09/25/14 at 1:01 PM revealed she monitors on a weekly basis for the timely response of the pharmacy recommendations by the physician to ensure they are addressed within fourteen (14) days.</p> <p>5. Interview with the Consultant Pharmacist on 09/25/14 at 10:27 AM revealed she will continue to conduct monthly medication regimen reviews of all residents on antipsychotic medications and will make recommendations as deemed necessary. She further stated the DON has monitors in place to evaluate for compliance.</p> <p>6. Interview with the Activities Director on 09/25/14 at 12:37 PM revealed she is a member of the QA Committee and has been informed of the progress and results of the audit tool and monitors in place at the facility.</p> <p>Interview with the Licensed Social Worker (LSW) on 09/25/14 at 12:42 PM revealed she is a member of the QA Committee and has been informed of the progress and results of the audit tools and monitors in place at the facility.</p>	F 428			