RECEIVED JUL 2015 OFFICE OF INSPECTOR GENERAL

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

PRINTED: 06/29/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>AMENDED<br><br>An Abbreviated Survey investigating Complaint #KY23207 was conducted on 05/12/15 through 05/18/15 and a Partial Extended Survey was conducted on 05/27/15 through 05/28/15. Complaint #KY23207 was substantiated with deficiencies cited at a Scope and Severity of a "J".<br><br>On the morning of 03/13/15, Resident #1 was alert to person, place and time, had no long term or short term memory deficits, was continent of bowel and bladder, was on a regular diabetic diet with no chewing or swallowing difficulties, his/her speech was understood and the resident understood others and he/she had no limitations in range of movement. On 03/13/15 at 2:35 PM, Resident #1 was administered two (2) as needed (PRN) medications, Lortab (for pain) and Ativan (for anxiety.) However, the licensed staff failed to document the medication was administered, failed to assess the resident after giving the medications and failed to document the effectiveness of the medications according to professional standards of quality and per the care plan.<br><br>Resident #1 was reported to have declines in cognition, weight bearing, transferring, continence, and verbalization after the PRN medications were administered. On 03/13/15 at approximately 6:00 PM, Resident #1's change in condition was reported to Licensed Practical Nurse (LPN) #2; however, there was no documented evidence licensed staff conducted an assessment related to the resident's decline | F 000 | Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: U. Edward Foley — TITLE: Interim Administrator — (X6) DATE: 07/06/15

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 | Continued From page 1<br>and notified the physician. The resident continued to decline and on 03/14/15 at 11:00 AM, approximately eighteen hours (18) hours later, he/she was unresponsive to sternal rubs and was sent out to the hospital, where it was determined the resident had a massive stroke. TPA (Tissue Plasminogen Activator), a medication given to break down blood clots, was not administered because the time the resident was last known well, was greater than three (3) hours prior to arrival." The resident was readmitted to the facility, on 03/27/15, with a diagnosis of Cerebrovascular Accident (CVA) and Dysphagia (swallowing difficulty), requiring the placement of a Gastrostomy Tube (G-Tube) and again after a hospital stay on 04/10/15, due to leakage of fluids around the G-Tube site. The resident remained non-verbal, dependent on a G-Tube for nutritional support, incontinent and totally dependent on staff for all care needs. The resident was sent to the hospital, on 05/06/15 at approximately 7:40 AM, for a possible infection from the G-Tube site and did not return to the facility.<br><br>Immediate Jeopardy (IJ) was identified in the areas of 42 CFR 483.10 Resident Rights at F157; 42 CFR 483.20 Resident Assessment at F281 and F282; 42 CFR 483.25 Quality of Care at F309; and CFR 483.75 Administration at F514, at a Scope and Severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. Immediate Jeopardy was identified on 05/18/15 and determined to exist on 03/13/15. The facility was notified of the Immediate Jeopardy on 05/18/15. An acceptable Allegation of Compliance (AoC) was received on 05/22/15, alleging the removal of Immediate Jeopardy on 05/21/15. | F 000 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:51 #988 P.003/033

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| F 000 | Continued From page 2<br><br>The State Survey Agency validated the Immediate Jeopardy was removed on 05/21/15, as alleged. The Scope and Severity was lowered to a "D" at 42 CFR 483.10 Resident Rights at F157; 42 CFR 483.20 Resident Assessment at F281 and F282; CFR 483.25 Quality of Care at F309; and CFR 483.75 Administration at F514, while the facility develops and implements the Plan of Correction (PoC); and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. | F 000 | F157-<br><br>1. Resident # 1 was discharged to the hospital on 05/06/2015 and did not return to the facility<br>2. On 05/18/2015 assessments were conducted for all current residents to determine if there were any medical needs requiring physician notification that the physician was not already aware of including vital signs, respiratory assessment, bowel sounds and changes in level of consciousness. This was completed by the Director of Nursing, Assistant Director of Nursing and Unit Managers. There were no concerns identified.<br>3. On 05/18/2015 the Regional Quality Manager re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers and MDS coordinator on physician notification for a significant change in condition based on the INTERACT program, developed under funding from CMS to prevent unnecessary acute care transfers to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a thorough assessment. Training included conducting an assessment based on resident condition with follow up assessments as well as physician notification and use of the 911 | |
| F 157 SS=J | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>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 | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:51 #988 P.004/033

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| F 157 | Continued From page 3<br>resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, review of hospital consultation reports and review of the facility's policy and procedure, it was determined the facility failed to notify the physician and responsible party regarding a change in condition for one (1) of three (3) sampled residents (Resident #1).<br><br>On 03/13/15 at approximately 6:00 PM, Resident #1 was noted with a decline in functional status as he/she was unable to assist with standing, needed the assistance of three (3) staff to transfer from the chair to the bed and was unable to eat his/her evening meal, after receiving two (2) as needed (PRN) medications, Lortab (for pain) and Ativan (for anxiety) at 2:35 PM.<br><br>Resident #1's change in condition was reported to Licensed Practical Nurse (LPN) #2 at the time; and, on 03/14/15 at 8:37 AM, Registered Nurse (RN) #1 identified Resident #1 was unresponsive; however, there was no documented evidence licensed staff notified the physician and Responsible Party. The resident continued to decline and on 03/14/15, approximately eighteen (18) hours later, he/she was unresponsive to sternal rubs and was sent out to the hospital, where it was determined the resident had a | F 157 | system in an emergent situation. Competency test were administered to validate understanding and all received 100% accuracy. Beginning 05/18/2015 and ongoing all licensed staff were re-educated b the DON, ADON and Unit Managers on physician notification for a significant change in condition based on the INTERACT program, developed under funding from CMS to prevent unnecessary acute care transfers to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a thorough assessment. Training included conducting an assessment based on resident condition with follow up assessments as well as physician notification and use of the 911 system in an emergent situation. Competency test were administered to validate understanding and all received 100% accuracy. No Licensed Nurse will work after 05/20/2015 without having received this re-education and pass competency test with 100% accuracy. Beginning 05/18/2015 all Nursing Assistants were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator related to reporting a change in condition to the Charge Nurse and if there are further concerns the CNA were then to report to the other nurses and up | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:51 #988 P.005/033

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| F 157 | Continued From page 4<br>massive stroke. According to the Emergency Room (ER) Physician's Consult Report, dated 03/14/15, the resident was admitted to the hospital on 03/14/15, with a diagnosis of Cerebrovascular Accident (stroke). TPA (Tissue Plasminogen Activator), a medication given to break down blood clots, was not administered because the time the resident was last known well, was greater than three (3) hours prior to arrival. The resident was admitted to the Intensive Care Unit, was unresponsive, non-communicative, and required a Gastric Feeding Tube (GT), due to the inability to sustain nutrition.<br><br>The facility's failure to notify the physician and the responsible party of a significant change in a resident has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/18/15 and determined to exist on 03/13/15. An acceptable Allegation of Compliance (AoC) was received on 05/22/15, alleging the Immediate Jeopardy was removed on 05/21/15, prior to exit. The State Survey Agency validated the Immediate Jeopardy was removed on 05/21/15, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.<br><br>The findings include:<br><br>Review of the facility's policy and procedure for the "Notification of Resident Change in Condition," undated, revealed clinicians should immediately inform the resident; consult with the resident's physician; and if known, notify the | F 157 | the chain of command . A competency test was administered with 100% accuracy. No Nursing Assistants will work after 05/20/2015 without having had this re-education and competency test.<br>4. Beginning 05/18/2015 the DON, ADON, MDS Coordinator or the Unit Managers will review with licensed nurses each shift all current residents conditions to determine if licensed staff were notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. This continued on each shift including weekends until removal of the Immediate Jeopardy then five times per week for twelve weeks thereafter. The DON, ADON or Unit Manager or MDS Coordinator will audit all narcotic records daily to identify any PRN pain medications given and compare to the Electronic Medical Record (EMAR) system to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented, This was completed daily until removal of the Immediate Jeopardy then completed five (5) times per week for twelve (12) weeks. Beginning 05/19/2015 the DON, ADON, or Unit Managers will review all nurses noted to determine if any significant change in condition has occurred without physician | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:52 #988 P.006/033

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| F 157 | Continued From page 5<br>resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status. If the change in the resident's condition is not crucial or significant, the resident's physician and family or legal representative will be notified at the earliest convenient time during regular business hours. The nurse may use the Interact Pathway/Guidelines for reference, but this should not supersede the nurses' judgment at bedside."<br><br>Review of the facility's policy and procedure titled, "Medication Administration," undated, revealed "to notify the physician of changes in condition related to the medication regimen (improvement or decline.)"<br><br>Closed record review revealed the facility admitted Resident #1 on 03/12/15, with diagnoses which included Morbid Obesity, Chronic Kidney Disease Stage III, Anxiety State, Depressive Disorder, and Diabetes Mellitus. Review of the Admission Minimum Data Set (MDS) assessment, dated 03/13/15, revealed the facility assessed the resident to be alert and oriented to person, place, and time; short and long term memory were intact; he/she understood with clear comprehension, was on a regular diabetic diet, was ambulatory with a walker, had no impairment in range of motion (ROM), and was continent of bowel and bladder.<br><br>Review of the Nursing Notes, dated 03/13/15 at 2:53 PM, revealed LPN #1 documented "Resident #1 was awake and alert, with some confusion. Medicated times one (1) for pain. Resident feeds self with tray set up. Appetite good. Fluids given with good results. Able to make wants and needs known. Resident is very needy and demanding. | F 157 | notification and that follow up assessment and documentation is occurring based on the clinical condition. This occurred daily including weekends until removal of the Immediate Jeopardy and then five (5) times per week for twelve weeks thereafter. The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly. | 06/05/15 |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:52 #988 P.007/033

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| F 157 | Continued From page 6<br>Continent of bowel and bladder. Feeds self with tray set up."<br><br>Interview with Certified Nurse Aide (CNA) #2, on 05/15/15 at 11:40 AM, revealed she worked the 2:30 PM -10:30 PM shift on 03/13/15. CNA #2 stated she was told Resident #1 had just received PRN medication and she observed the resident was up in a chair and "dozing off" at the start of the shift. CNA #2 revealed she tried to wake the resident "just before supper," and the resident would not wake up or eat supper. The CNA stated the resident would open his/her eyes but go right back to sleep and had to be assisted back to bed. She stated the resident had previously been able to transfer himself/herself with a walker.<br><br>Interview with CNA #1, on 05/15/15 at 11:35 AM, revealed he had worked with Resident #1 on 03/13/15, on the 2:30 PM -10:30 PM shift and noticed a change in the resident, from the previous afternoon (03/12/15.) CNA #1 stated the resident previously was able to make his/her needs known, able to move from side-to-side and hold on to the side rail to use the bedpan, and was able to ambulate with a walker, after the resident was assisted out of the bed or chair. CNA #1 stated on 03/13/15, at approximately 6:00 PM, the resident was "sleeping in a chair and would not wake up." The CNA stated he called on two (2) Emergency Medical Technicians (EMTs), who were in the building for another resident, to assist him to get the resident out of the chair as he/she was "dead weight," and unable to assist with standing or pivoting. CNA #1 stated the resident's spouse was visiting and stated he/she had "never seen the resident like this." CNA #1 stated vital signs were taken and | F 157 | | |



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| F 157 | Continued From page 7 | F 157 | | |

were within the resident's normal range and he informed LPN #2 of his (CNA #1) and the spouse's concerns and was "assured it was due to the PRN medications."

Interview with Resident #1's spouse, on 05/12/15 at 9:50 AM and on 05/17/15 at 5:11 PM, revealed the spouse had visited the resident on 03/13/15 "after supper" and the resident did not eat his/her supper. Resident #1's spouse stated the resident "looked drugged out or over-medicated." The Spouse stated he/she stayed until about 9:00 PM and the resident "looked like (he/she) was gone." The Spouse stated the resident had never had this type of reaction to the medication before and stated he/she never usually slept more than two (2) or three (3) hours at a time, because he/she was in so much pain all the time, from a spinal fracture in December 2014. Further interview with the resident's Spouse revealed he/she told two (2) or three (3) staff members he/she was concerned. He/She stated he/she felt they "should have gotten (the resident) out then." He/She also stated he requested vital signs be taken and was told they were "fine" and the resident was just resting from the PRN medication.

Interview with LPN #1, on 05/15/15 at 9:55 AM; and, on 05/18/15 at 3:38 PM, revealed she had worked the 6:00 AM - 6:00 PM shift on 03/13/15 when the resident had repetitive complaints and was "needy and demanding". LPN #1 stated both the resident and the spouse requested the resident have something for pain and anxiety. The LPN stated she had given the resident Lortab 5/325 milligrams (mg) and Ativan 0.5 mg, as a PRN, on 03/13/15, at approximately 2:30 PM, for the resident's complaints of nervousness and



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| F 157 | Continued From page 8 | F 157 | | |

chronic pain. She stated this was the first time she had administered these medications to the resident. The LPN stated no one made her aware that Resident #1 had a change in condition and the resident was "OK" when she left at 6:00 PM so she had no need to call the physician. However, review of the Nursing Notes and review of the March 2015 Electronic Medication Administration Record (EMAR) revealed there was no documented evidence the nurse assessed the resident to determine the effectiveness of the PRN medications and if there was a significant change in condition to determine the need to notify the Physician/Responsible Party.

Interview with LPN #2, on 05/15/15 at 11:10 AM; and, on 05/16/15 at 3:28 PM, revealed the LPN worked the 6:00 PM - 6:00 AM shift, on 03/13/15. She stated the resident was sleeping as she made rounds at the start of her shift. LPN #2 stated the resident's spouse was visiting at the bedside and the resident never fully awakened, throughout the night, yet pulled his/her arm away when vital signs and accu-checks (for blood sugar testing) were administered. The LPN stated no one made her aware of any change in the resident's condition. LPN #2 stated the resident was resting well from receiving the PRN medications and she felt there was no change in condition to warrant calling the physician. However, review of the Nurse's Notes revealed no documented evidence LPN #2 assessed the resident to determine if there was a need to notify the physician.

Review of a Nurse's Note documented by Registered Nurse (RN) #1, dated 03/14/15 at 8:47 AM, revealed "Resident has been very



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| F 157 | Continued From page 9<br>unresponsive, I believe this to be because (he/she) had received pain medication prior to my shift, according to report, (he/she) does not react particularly well" and has "sluggish pupil constriction." There was no documented evidence the physician was notified of the resident's condition. The next entry, made by RN #1, on 03/14/15 at 11:36 AM, revealed the resident was unresponsive to two (2) sternal rubs and sent to the Emergency Room (ER) at 11:34 AM.<br><br>Interview with RN #1, on 05/15/15 at 8:25 PM and 10:40 AM; and, on 05/17/15 at 4:09 PM, revealed he worked the 6:00 AM - 6:00 PM shift on 03/14/15 and Resident #1 was "mostly unresponsive" when he started his shift at 6:00 AM and remained that way, until sent to the ER at 11:34 AM. He stated the resident's vital signs were stable and the Pulse Oximeter (used to measure the oxygen saturation of the blood) was 96 percent and the heart rate was 109. RN #1 stated he felt he had a "window of time to work in" and he felt the PRN medications were "still hanging around." The RN stated he did an assessment of the resident at 8:47 AM and there was no facial drooping, yet the resident was unable to follow commands to stick out his/her tongue or grip his (RN #1) hands, to test for grip strength. He stated he had to "hold (the resident's) eyes open" to assess the pupils, which were noted to have been "sluggish." The RN stated he was aware of the need to call the physician of any changes of condition. RN #1 stated he had graduated from RN school five (5) months ago and felt the need to get a second opinion on the resident's condition from another nurse working at the time. He stated RN #2 came to assess the resident at approximately | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:53 #988 P.011/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 157 | Continued From page 10<br>11:00 AM and administered two (2) sternal rubs on the resident and the process was begun to get the resident to the ER. The resident's spouse and physician were called and the resident left the facility at 11:34 AM. The RN stated "looking back, I probably should have sent (him/her) out earlier."<br><br>Interview with RN #2, on 05/14/15 at 9:15 AM, revealed she was not the resident's assigned nurse on 03/14/15 but was working another area, at approximately 11:00 AM, when she was asked to come and take a look at the resident. The RN stated the resident was not responsive to sternal rubs. She assisted the staff to get the resident to the ER, as the resident was a "Full Code".<br><br>Review of the Hospital Physician Consultation Reports, dated 03/14/15, revealed the Attending Physician's clinical impression was a "non-traumatic cerebrovascular accident involving a distal branch of the posterior cerebral artery. TPA was not administered because the time the resident was last known well, was greater than three (3) hours prior to arrival. The resident had suffered an Acute Cerebrovascular Accident (CVA-stroke); was admitted to the Intensive Care Unit; was unresponsive, non-communicative, and required a Gastric Feeding Tube (GT), due to the inability to sustain nutrition.<br><br>Interview with the Assistant Director of Nursing (ADON), on 05/18/15 at 6:00 PM, revealed her expectation was for staff to call the physician with any change of condition.<br><br>Interview with the Director of Nursing (DON), on 05/18/15 at 5:30 PM, revealed she felt if the LPN had entered the PRN medications into the EMAR, | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:53 #988 P.012/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 157 | Continued From page 11<br>there would have been an automatic pop up to remind the nurse that a follow-up assessment was due, regarding the effectiveness or possible side-effects of the PRN medications. However, this was not done. Further interview revealed there was no documented evidence the resident was assessed after the PRN medications were given. She stated the physician should have been notified as soon as a change of condition was noted.<br><br>Interview with the Administrator, on 05/18/15 at 5:05 PM, revealed the Administrator had been made aware of the resident having been administered the PRNs, although she was unsure when. However, she stated the staff should have called the physician when they first noticed the change in condition.<br><br>During an interview with Resident #1's attending physician, on 05/15/15 at 12:16 PM, he stated "You have to look back to the last time the resident was normal before an acute intervention (as TPA) could have been administered effectively and this has to be within the three (3) hour window of time, from the last resident's normal." He revealed the administration of the Lortab and Ativan would not have caused the stroke. He stated the resident having been drowsy, early on after the administration of the medications, would not have been unusual. However, the physician stated if the resident's condition had "drastically changed," he would have expected the licensed staff to have made him aware of the change of condition.<br><br>** The facility implemented the following actions to remove the Immediate Jeopardy: | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:54 #988 P.013/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

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| F 157 | Continued From page 12<br>1. Resident #1 no longer resides at the facility.<br><br>2. On 05/18/15, assessments were conducted for eighty-one (81) of eighty-one (81) current residents, to determine if there were any medical needs requiring physician notification that the physician was not already aware of. This assessment included vital signs, respiratory assessment, bowel sounds, and changes in level of consciousness. There were no identified residents with a change in condition that the physician was not aware of, or that required further physician notification.<br><br>3. The DON and ADON conducted an audit of all current residents, on 05/18/15, to identify any resident who had received an as needed (PRN) pain medication, in the past twenty four hours and to ensure that a follow up to the effectiveness or adverse side effects of the PRN pain medication was completed. There were no noted adverse side effects of any PRN pain and all had effect relief of pain and there were no identified residents with a change in condition that the physician was not aware of or requiring further physician notification.<br><br>4. On 05/18/15 through 05/19/15 the DON, ADON, Unit Managers and the MDS Coordinator reviewed all current residents' plans of care to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. On 05/18/15, the Regional Quality Manager re-educated the DON, ADON, Unit Managers for all three units (Units One (1), Two (2) and Three (3) and the MDS Coordinator on Physician Notification for a significant change in condition, | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:54 #988 P.014/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

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| F 157 | Continued From page 13<br>based on the INTERACT program, developed under funding from CMS (Centers for Medicare and Medicare Services), to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a through assessment. Training also included conducting an assessment based on resident condition, follow up assessments as well as physician notification for a significant change condition, as well as utilizing the 911 system in an emergent situation. In addition, they were educated on the requirement to follow the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the physician must be notified. Competency tests were administered, to validate understanding and all received 100% accuracy.<br><br>6. On 05/18/15, all license staff was re-educated by the DON, ADON and Unit Managers Physician Notification for a significant change in condition, based on the INTERACT program, developed under funding from CMS, to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a through assessment. Training also included conducting an assessment based on resident condition, follow up assessments as well as physician notification for a significant change condition, as well as utilizing the 911 system in an emergent situation. In addition, they were educated on the requirement to follow the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice that the physician must be notified. | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:54 #988 P.015/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 157 | Continued From page 14<br>Competency tests were administered, to validate understanding and all received 100% accuracy. No licensed staff will work after 05/20/15 without having completed this re-education and competency test. All newly employed licensed nurses will receive this education prior to taking sole charge of a unit. On 05/18/15 and ongoing all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. In addition, re-education was provided related to reporting a change in condition to the Charge Nurse. If there are further concerns, the CNAs were then to report to the other nurse and up the chain of command. A competency test was administered to validate understanding with a minimum score of 100% accuracy and all CNAs passed with 100 % accuracy. No staff will work at the facility, after 05/20/15, without having this training and competency test with a minimum score of 100% accuracy, any staff not receiving 100% accuracy will be immediately re-educated and will not work until competency test is 100% accurate.<br><br>7. Beginning 05/18/15, the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents' conditions each shift, to determine if licensed staff were notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. This will continue on each shift including weekends until the Immediate Jeopardy is lifted, then five (5) times per week for twelve (12) weeks thereafter.<br><br>8. The DON, ADON or Unit Manager will review | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:54 #988 P.016/033

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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 157 | Continued From page 15<br>five (5) residents' plans of care per week for twelve (12) weeks to evaluate if interventions are in place and being followed. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee weekly until substantial compliance then monthly thereafter.<br><br>9. The DON, ADON, or Unit Managers, or the MDS Coordinator audited all narcotic records daily, to identify any PRN pain medication given and compare to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented, weekly including weekends, until the Immediate Jeopardy was lifted then five (5) times a week for twelve (12) weeks thereafter.<br><br>10. An Ad Hock Quality Assurance and Performance Improvement (QAPI) Committee was convened to review the facility investigation and concerns. An allegation of compliance was developed and reviewed with the Medical Director, who attended via phone. The results of all audits will be reviewed with the Quality Assurance and Improvement Committee weekly, until substantial compliance has been achieved, then monthly thereafter. The QAPI committee will meet weekly or anytime concerns are identified until substantial compliance, then monthly thereafter.<br><br>** The State Survey Agency validated the corrective actions taken by the facility as follows:<br><br>1. The resident no longer resides at the facility.<br><br>2. Review of the 100% (81 of 81) resident assessments, dated 05/18/15, revealed the residents were assessed to determine if there | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:55 #988 P.017/033

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| F 157 | Continued From page 16<br>were any medical needs to warrant physician notification with no concerns identified. Chart reviews were completed on Residents #4, #5 and #6 with no identified areas of concern.<br><br>3. Review of the DON and ADON conducted audits of all current residents, dated 05/18/15 to identify any resident that required a PRN medication and to ensure a follow-up assessment, monitoring for any side effect or reactions and to evaluate the effectiveness of the PRN, revealed they were completed without concerns.<br><br>4. Review of the audits dated 05/18/15 through 05/19/15 completed by the DON, ADON, Unit Managers and MDS Coordinator revealed all current residents' plans of care were reviewed to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. Materials and sign-in sheets, dated 05/18/15,were reviewed regarding in-services held by the Regional Quality Manager, for the Nursing Administration Staff and re-training on the EMAR system, documentation of PRN medications, physician notification, care planning and the INTERACT process were reviewed. Review of the Competency testing revealed staff had a 100% pass rate with no concerns noted. Interview with the DON, on 05/28/15 at 10:45 AM, revealed she and the Administrative Nurses had all had the re-education completed by the Regional Quality Manager related to assessments, implementing the care plan, change of condition, documentation of PRN medications, and physician notification and the INTERACT process. | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:55 #988 P.018/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 157 | Continued From page 17<br><br>6. Materials and sign-in sheets, dated 05/18/15-05/20/15, revealed the DON, ADON and Unit Managers re-educated all licensed staff on the same requirements with a competency test with a minimum score of 100% accuracy required. Staff interviews conducted on 05/28/15 with LPN #4 at 8:35 AM; LPN #5 at 8:51 AM; RN #2 at 10:12 AM; LPN #6 at 10:25 AM revealed the training had been completed and all the licensed staff had passed the test. On 05/18/15 through 05/20/15 all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse and notify the nurse of a change in condition and going up the chain of command. There were competency tests with a minimum score of 100% accuracy. Staff interviews on 05/28/15 with CNA #4 at 9:17 AM; CNA #5 at 9:25 AM; CNA #6 at 10:35 AM; and CNA #7 at 10:38 AM revealed the staff verified their training had been done and they had been tested regarding the care plans and notification of a change in condition.<br><br>7. Reviews of the every shift audits, dated 05/18/15 to 05/20/15, revealed the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents conditions each shift, to determine if licensed staff was notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. Interview with the DON, on 05/28/15 at 10:45 AM, revealed audits for residents' change of condition, notification of physician, and follow-up assessments were done on each shift | F 157 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:55 #988 P.019/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 157 | Continued From page 18<br>until the AoC was accepted, and were now being done five times a week for twelve weeks. She stated the results of these audits will be reviewed in the QA Meetings.<br><br>8. Review of audits conducted by the DON, ADON or Unit Manager revealed five (5) residents' plans of care were reviewed to evaluate if interventions were in place and being followed.<br><br>9. Review of daily audits conducted by the DON, ADON, Unit Managers, or the MDS Coordinator revealed all narcotic records were audited daily, to identify any PRN pain medication administered and compared to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented.<br><br>10. A review of the QA meetings, dated 05/20/15, 05/21/15 and 05/22/15, revealed the agenda regarded concerns with the allegation deficiencies as well as the annual survey deficiencies, complaint, and facility self-reported complaints. The meeting was attended by the Administrator, DON, Activities Director, MDS Coordinator, Business Office Manager, Dietary Services Manager, Medical Records, Housekeeping and Maintenance and the Marketing Manager. Interview with the Medical Clinical Officer (MCO) revealed the Medical Director attended the 05/18/15 meeting, by phone and was kept abreast of any concerns and the meetings were to continue weekly, then monthly until resolved. | F 157 | | |
| F 281 SS=J | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS | F 281 | F281<br><br>1. Resident # 1 was discharged to the hospital on 05/06/2015 and did not return to the facility.<br>2. On 05/18/2015 assessments were conducted for all current residents to determine if there were any medical needs requiring physician notification that the physician was | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:55 #988 P.020/033

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| F 281 | Continued From page 19<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, review of the hospital's Physician Consultation Reports, the facility's policy and procedure and the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #27 "Components of Licensed Practical Nursing (LPN) Practice", it was determined the facility failed to ensure services provided by the facility met the professional standards of quality for one (1) of three (3) sampled residents (Resident #1).<br><br>On 03/13/15 at 2:35 PM, Resident #1 was administered two as needed (PRN) medications, Lortab (for pain) and Ativan (for anxiety.) LPN #1 failed to assess the resident according to professional standards of quality, after giving the medications and failed to document the effectiveness of the medications. LPN #2 failed to assess the resident at the beginning of the shift and also failed to assess the resident after Certified Nurse Aide (CNA) #1 and a family member complained the resident needed the assistance of three (3) staff to assist back into bed; and, when staff made the licensed nurses aware they were unable to awaken the resident. The resident continued to decline and on 03/14/15, approximately eighteen (18) hours later, he/she was unresponsive to sternal rubs and was sent out to the hospital, where it was determined the resident had a massive stroke.<br><br>The facility's failure to ensure care was provided | F 281 | not already aware of including vital signs, respiratory assessment, bowel sounds and changes in level of consciousness. This was completed by the Director of Nursing, Assistant Director of Nursing and Unit Managers. There were no concerns identified. On 05/18/2015 the Director of Nursing and Assistant Director of Nursing conducted an audit of all current resident to identify any resident who had received an as needed (PRN) pain medication in the past twenty four hours and to ensure that a follow up to the effectiveness or adverse side effects of the PRN pain medication was completed. There were no noted adverse side effects of any PRN pain medications and all had effective relief of pain.<br>3. On 05/18/2015 the Regional Quality Manager re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers and MDS coordinator on physician notification for a significant change in condition based on the INTERACT program, developed under funding from CMS to prevent unnecessary acute care transfers to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a thorough assessment. Training included conducting an assessment based on resident condition with follow up | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:56 #988 P.021/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 281 | Continued From page 20<br>according to the professional standards of practice has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 05/18/15 and determined to exist on 03/13/15. An acceptable Allegation of Compliance (AoC) was received on 05/22/15, alleging the IJ was removed on 05/21/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/21/15, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.<br><br>The findings include:<br><br>Review of the KBN AOS #27 "Components of Licensed Practical Nursing (LPN) Practice", last revised 06/2014, revealed components of the LPN practice included assessment and interpretation of data. Assessment includes observations of appearance and behavior; measurements of physical structure and physiologic function; and observations of a resident's subjective and objective signs and symptoms. Interpreting data includes recognizing existing relationships between data gathered and a resident's health status, established plan of care and medical treatment regimen; determining the resident's need for nursing intervention based upon data gathered regarding the resident's health status, ability to care for self, and established plan of care; and appropriate consultation.<br><br>Review of Resident #1's closed record revealed the facility admitted the resident on 03/12/15 with diagnoses which included Contusion of the Knee | F 281 | assessments as well as physician notification and use of the 911 system in an emergent situation. Competency test were administered to validate understanding and all received 100% accuracy. Beginning 05/18/2015 and ongoing all licensed staff were re-educated b the DON, ADON and Unit Managers on physician notification for a significant change in condition based on the INTERACT program, developed under funding from CMS to prevent unnecessary acute care transfers to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a thorough assessment. Training included conducting an assessment based on resident condition with follow up assessments as well as physician notification and use of the 911 system in an emergent situation. Training also included documentation of follow up assessment for effectiveness and adverse side effects in the emar system. Competency test were administered to validate understanding and all received 100% accuracy. No Licensed Nurse will work after 05/20/2015 without having received this re-education and pass competency test with 100% accuracy. Beginning 05/18/2015 all Nursing Assistants were re-educated with competency test by the DON, | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:56 #988 P.022/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 281 | Continued From page 21<br>and Cellulitis; General Osteoarthritis; Diabetes Mellitus, Type II; Morbid Obesity; and Chronic Kidney Disease, Stage III. Review of the Admission Minimum Data Set, dated 03/13/15, revealed the facility assessed the resident as being alert and oriented to person, place, and time; understood and understands with clear comprehension, on a regular diabetic diet, ambulatory with a walker, continent of bowel and bladder and the resident's short and long term memory were intact and he/she had no impairment in range of motion (ROM).<br><br>Review of a Nursing Note, dated 03/13/15 at 2:53 PM, revealed LPN #1 administered medication for pain and the resident was awake and alert, with some confusion. Further review of the Nursing Notes revealed there was no documented evidence the nurse assessed the resident for the effectiveness of the medication.<br><br>Review of Resident #1's March 2015 Electronic Medication Administration Records (EMARs) and further review of the Nursing Notes revealed there was no documented evidence LPN #1 assessed Resident #1 to determine the effectiveness of the PRN medication.<br><br>Review of the Nurses' Notes for Resident #1, dated 03/13/15 at 2:53 PM, reveled LPN #1 documented the resident was "awake and alert, with some confusion. Medicated x1 for pain". The next entry, documented by RN #1, dated 03/14/15 at 2:47 AM, revealed " resident has been very unresponsive, I believe this to be because he/she had received pain medication prior to my shift, and according to report, he/she does not react well and has sluggish pupil constriction". The next entry made by RN #1, on 03/14/15 at 11:36 AM, | F 281 | ADON, and the Unit Managers or MDS Coordinator related to reporting a change in condition to the Charge Nurse and if there are further concerns the CNA were then to report to the other nurses and up the chain of command . A competency test was administered with 100% accuracy. No Nursing Assistants will work after 05/20/2015 without having had this re-education and competency test.<br><br>4. Beginning 05/18/2015 the DON, ADON, MDS Coordinator or the Unit Managers will review with licensed nurses each shift all current residents conditions to determine if licensed staff were notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. This continued on each shift including weekends until removal of the Immediate Jeopardy then five times per week for twelve weeks thereafter. The DON, ADON or Unit Manager or MDS Coordinator will audit all narcotic records daily to identify any PRN pain medications given and compare to the Electronic Medical Record (EMAR) system to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented and review of EMAR records to validate that follow up documentation is | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:56 #988 P.023/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 281 | Continued From page 22<br>revealed the resident was unresponsive to two (2) sternal rubs and was sent to the Emergency Room (ER) at 11:34 AM. Further review of the EMARs revealed no evidence of the documentation of the prn medications and no evidence of follow-up assessments of the prn medication.<br><br>Interview with LPN #1, on 05/15/15 at 9:55 AM and, on 05/18/15 at 3:38 PM, revealed she worked the 6:00 AM to 6:00 PM shift on 03/13/15. LPN #1 stated the resident had repetitive complaints and both the resident and his/her spouse requested the resident have something for pain and anxiety. The LPN stated she had given Lortab five (5)/325 milligrams (mg) and Ativan 0.5 mg, as a PRN, on 03/13/15, at approximately 2:30 PM, for the resident's complaints of nervousness and chronic pain. LPN #1 stated this was the first time the resident had received these medications, at the facility. The LPN stated she was unsure why the Ativan was not mentioned in the Nursing Notes, the medications were not documented on the EMARS and the results of the effectiveness of the PRNs were not documented. LPN #1 stated it had been a very busy week and she "probably forgot." The LPN was unable to remember if the resident had been assessed, prior to her completing her shift at 6:00 PM. She stated the resident was "sitting up eating supper when I left and was OK." However, review of the Meal Consumption Records for 03/13/15 revealed Resident #1 "refused" supper.<br><br>Interview with Certified Nursing Assistant (CNA) #2, on 05/15/15 at 11:40 AM, revealed she was told Resident #1 had just received PRN medication and the resident was up in a chair and | F 281 | present for PRN medications, This was completed daily until removal of the Immediate Jeopardy then completed five (5) times per week for twelve (12) weeks. Beginning 05/19/2015 the DON, ADON, or Unit Managers will review all nurses noted to determine if any significant change in condition has occurred without physician notification and that follow up assessment and documentation is occurring based on the clinical condition. This occurred daily including weekends until removal of the Immediate Jeopardy and then five (5) times per week for twelve weeks thereafter. The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly. | 06/05/15 |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:57 #988 P.024/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 281 | Continued From page 23<br>"dozing off" at the start of the shift. CNA #2 stated she tried to wake the resident "just before supper" and the resident would not wake up or eat supper. The CNA revealed the resident would open his/her eyes but go right back to sleep and had to be assisted back to bed. The CNA stated the resident had previously been able to transfer himself/herself with a walker.<br><br>Interview with Certified Nurse Aide (CNA) #1, on 05/15/15 at 11:35 PM, revealed Resident #1 who had been alert, continent, able to verbalize needs and ambulate with the assistance of a walker on 03/12/15 had declined on 03/13/15 and was unable to awaken and needed the assistance of the CNA and two (2) ambulance workers to assist the resident back to bed as the resident was "dead weight" at approximately 6:00 PM. The CNA stated he reported this to LPN #2, who "assured" him, it "was the PRN medication."<br><br>Interview with Resident #1's Spouse, on 05/12/15 at 9:50 AM and 05/17/15 at 5:11 PM, revealed he/she had visited the resident on 03/13/15 "after supper" and stated the resident "looked drugged out or over-medicated." The spouse stated he/she stayed until about 9:00 PM and the resident "looked like (he/she) was gone." The spouse stated the resident had been on the same PRN medications at home and had never had this type of reaction to the medication before. He/She stated the resident never usually slept more than two (2) or three (3) hours at a time, because he/she was in so much pain all the time, from a spinal fracture in December 2014. Further interview revealed he/she had told two (2) or three (3) staff members of these concerns, and he/she felt they "should have gotten (the resident) out then." The spouse stated he/she also | F 281 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:57 #988 P.025/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

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| F 281 | Continued From page 24<br>requested vital signs be taken and was told they were "fine" and the resident was just resting from the PRN medication.<br><br>Interview with LPN #2 on 05/15/15 at 11:10 AM; and, on 05/16/15 at 3:28 PM, revealed she made rounds at the start of her shift and the resident was sleeping. LPN #2 stated the resident "never completely woke up" during her shift, 6:00 PM to 6:00 AM on 03/13/15, yet pulled his/her arm away when vital signs and accu-checks (for blood sugar testing) were administered and these were within the resident's normal range. LPN #2 stated the resident was resting well from receiving the PRN medications and she did not feel the need for further assessments. Further review of the Nursing Notes revealed there was no documented evidence Resident #1 was assessed during her shift to determine if the resident had experienced a change in cognitive levels and responsiveness or a further investigation was conducted to determine if the resident had responded like this in the past to these medications.<br><br>Review of the Meal Consumption Records revealed breakfast "did not occur," on 03/14/15.<br><br>Review of a Nursing Note documented by Registered Nurse (RN) #1, dated 03/14/15 at 8:47 AM, revealed the resident had been unresponsive and the RN believed it was due to the pain medication. The Notes revealed the resident had "sluggish pupil constriction." However, there was no documented evidence the nurse notified the physician of the resident's change in condition or of any further assessment until 03/14/15 at 11:36 AM, when the resident was unresponsive to two (2) sternal rubs and sent to | F 281 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:57 #988 P.026/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

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| F 281 | Continued From page 25<br>the Emergency Room (ER) at 11:34 AM.<br><br>Interview with RN #1, on 05/15/15 at 8:25 PM and 10:40 AM; and, on 05/17/15 at 4:09 PM, revealed Resident #1 was "mostly unresponsive" when he started his shift at 6:00 AM and remained that way, until sent to the ER at 11:34 AM. The RN stated he did an assessment of the resident at 8:47 AM and stated there was no facial drooping, yet the resident was unable to follow commands to stick out his/her tongue or grip the RN's hands, to test for grip strength. RN #1 stated he had to "hold (his/her) eyes open" to assess the pupils, which were noted to have been "sluggish." The RN stated he felt the need to get a second opinion on the resident's condition from another nurse working at the time. He stated RN #2, came to assess the resident at approximately 11:00 AM and administered two (2) sternal rubs to the resident and the process was begun to get the resident to the ER.<br><br>Interview with RN #2, on 05/14/15 at 9:15 AM, revealed on 03/14/15 at approximately 11:00 AM, she was asked to come and take a look at Resident #1. The RN stated the resident was not responsive to sternal rubs and she assisted the staff to get the resident to the ER, as the resident was a "Full Code".<br><br>Review of the Hospital Physician Consultation Reports, dated 03/14/15, revealed the resident was diagnosed with an Acute Cerebrovascular Accident (CVA-stroke). "TPA was not administered because the time the resident was last known well, was greater than three (3) hours prior to arrival." The resident was admitted to the Intensive Care Unit, and was unresponsive, non-communicative, and required a Gastric | F 281 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:57 #988 P.027/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

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| F 281 | Continued From page 26<br>Feeding Tube (GT), due to the inability to sustain nutrition.<br><br>Interview with the Assistant Director of Nursing (ADON), on 05/18/15 at 6:00 PM, revealed she would have expected the staff to have assessed the resident and called the physician with any change of condition.<br><br>Interview with the Director of Nursing (DON), on 05/18/15 at 5:30 PM, revealed there was no evidence the resident was fully assessed after the PRN medications; nor after concerns from CNA #1 and the spouse were made to the nurses. She stated the LPNs should have assessed for a change in cognition and reported this to the physician.<br><br>Interview with the Administrator, on 05/18/15 at 5:05 PM, revealed the staff should have assessed the resident and called the physician, when they first noticed the change in cognition.<br><br>Interview with Resident #1's attending physician, on 05/15/15 at 12:16 PM, revealed the administration of the Lortab and Ativan would not have caused the stroke. He stated the resident having been drowsy, early on after the administration of the medications, would not have been unusual. However, the physician stated if the resident's condition had "drastically changed," he would have expected the licensed staff to have made him aware of the change of condition.<br><br>** The facility implemented the following actions to remove the Immediate Jeopardy:<br><br>1. Resident #1 no longer resides at the facility. | F 281 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:58 #988 P.028/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 281 | Continued From page 27<br>2. On 05/18/15, assessments were conducted for eighty-one (81) of eighty-one (81) current residents, to determine if there were any medical needs requiring physician notification that the physician was not already aware of. This assessment included vital signs, respiratory assessment, bowel sounds, and changes in level of consciousness. There were no identified residents with a change in condition that the physician was not aware of, or that required further physician notification.<br><br>3. The DON and ADON conducted an audit of all current residents, on 05/18/15, to identify any resident who had received an as needed (PRN) pain medication, in the past twenty four hours and to ensure that a follow up to the effectiveness or adverse side effects of the PRN pain medication was completed. There were no noted adverse side effects of any PRN pain and all had effect relief of pain and there were no identified residents with a change in condition that the physician was not aware of or requiring further physician notification.<br><br>4. On 05/18/15 through 05/19/15 the DON, ADON, Unit Managers and the MDS Coordinator reviewed all current residents' plans of care to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. On 05/18/15, the Regional Quality Manager re-educated the DON, ADON, Unit Managers for all three units (Units One (1), Two (2) and Three (3) and the MDS Coordinator on Physician Notification for a significant change in condition, based on the INTERACT program, developed under funding from CMS (Centers for Medicare | F 281 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:58 #988 P.029/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCCRACKEN NURSING AND REHABILITATION CENTER | 667 MCGUIRE AVE. PADUCAH, KY 42001 |

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| F 281 | Continued From page 28<br>and Medicare Services), to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a through assessment. Training also included conducting an assessment based on resident condition, follow up assessments as well as physician notification for a significant change condition, as well as utilizing the 911 system in an emergent situation. In addition, they were educated on the requirement to follow the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the physician must be notified. Competency tests were administered, to validate understanding and all received 100% accuracy.<br><br>6. On 05/18/15, all license staff was re-educated by the DON, ADON and Unit Managers Physician Notification for a significant change in condition, based on the INTERACT program, developed under funding from CMS, to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a through assessment. Training also included conducting an assessment based on resident condition, follow up assessments as well as physician notification for a significant change condition, as well as utilizing the 911 system in an emergent situation. In addition, they were educated on the requirement to follow the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice that the physician must be notified. Competency tests were administered, to validate understanding and all received 100% accuracy. | F 281 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:58 #988 P.030/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 281 | Continued From page 29<br>No licensed staff will work after 05/20/15 without having completed this re-education and competency test. All newly employed licensed nurses will receive this education prior to taking sole charge of a unit. On 05/18/15 and ongoing all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. In addition, re-education was provided related to reporting a change in condition to the Charge Nurse. If there are further concerns, the CNAs were then to report to the other nurse and up the chain of command. A competency test was administered to validate understanding with a minimum score of 100% accuracy and all CNAs passed with 100 % accuracy. No staff will work at the facility, after 05/20/15, without having this training and competency test with a minimum score of 100% accuracy, any staff not receiving 100% accuracy will be immediately re-educated and will not work until competency test is 100% accurate.<br><br>7. Beginning 05/18/15, the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents' conditions each shift, to determine if licensed staff were notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. This will continue on each shift including weekends until the Immediate Jeopardy is lifted, then five (5) times per week for twelve (12) weeks thereafter.<br><br>8. The DON, ADON or Unit Manager will review five (5) residents' plans of care per week for twelve (12) weeks to evaluate if interventions are | F 281 | | |



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:58 #988 P.031/033

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 281 | Continued From page 30 | F 281 | | |

in place and being followed. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee weekly until substantial compliance then monthly thereafter.

9. The DON, ADON, or Unit Managers, or the MDS Coordinator audited all narcotic records daily, to identify any PRN pain medication given and compare to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented, weekly including weekends, until the Immediate Jeopardy was lifted then five (5) times a week for twelve (12) weeks thereafter.

10. An Ad Hock Quality Assurance and Performance Improvement (QAPI) Committee was convened to review the facility investigation and concerns. An allegation of compliance was developed and reviewed with the Medical Director, who attended via phone. The results of all audits will be reviewed with the Quality Assurance and Improvement Committee weekly, until substantial compliance has been achieved, then monthly thereafter. The QAPI committee will meet weekly or anytime concerns are identified until substantial compliance, then monthly thereafter.

** The State Survey Agency validated the corrective actions taken by the facility as follows:

1. The resident no longer resides at the facility.

2. Review of the 100% (81 of 81) resident assessments, dated 05/18/15, revealed the residents were assessed to determine if there were any medical needs to warrant physician notification with no concerns identified. Chart



From:MCKRACKEN CO NURSE REHAB 1 270 443 6211 07/06/2015 14:59 #988 P.032/033

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| F 281 | Continued From page 31<br>reviews were completed on Residents #4, #5 and #6 with no identified areas of concern.<br><br>3. Review of the DON and ADON conducted audits of all current residents, dated 05/18/15 to identify any resident that required a PRN medication and to ensure a follow-up assessment, monitoring for any side effect or reactions and to evaluate the effectiveness of the PRN, revealed they were completed without concerns.<br><br>4. Review of the audits dated 05/18/15 through 05/19/15 completed by the DON, ADON, Unit Managers and MDS Coordinator revealed all current residents' plans of care were reviewed to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. Materials and sign-in sheets, dated 05/18/15,were reviewed regarding in-services held by the Regional Quality Manager, for the Nursing Administration Staff and re-training on the EMAR system, documentation of PRN medications, physician notification, care planning and the INTERACT process were reviewed. Review of the Competency testing revealed staff had a 100% pass rate with no concerns noted. Interview with the DON, on 05/28/15 at 10:45 AM, revealed she and the Administrative Nurses had all had the re-education completed by the Regional Quality Manager related to assessments, implementing the care plan, change of condition, documentation of PRN medications, and physician notification and the INTERACT process.<br><br>6. Materials and sign-in sheets, dated | F 281 | | |



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| F 281 | Continued From page 31<br>reviews were completed on Residents #4, #5 and #6 with no identified areas of concern.<br><br>3. Review of the DON and ADON conducted audits of all current residents, dated 05/18/15 to identify any resident that required a PRN medication and to ensure a follow-up assessment, monitoring for any side effect or reactions and to evaluate the effectiveness of the PRN, revealed they were completed without concerns.<br><br>4. Review of the audits dated 05/18/15 through 05/19/15 completed by the DON, ADON, Unit Managers and MDS Coordinator revealed all current residents' plans of care were reviewed to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. Materials and sign-in sheets, dated 05/18/15,were reviewed regarding in-services held by the Regional Quality Manager, for the Nursing Administration Staff and re-training on the EMAR system, documentation of PRN medications, physician notification, care planning and the INTERACT process were reviewed. Review of the Competency testing revealed staff had a 100% pass rate with no concerns noted. Interview with the DON, on 05/28/15 at 10:45 AM, revealed she and the Administrative Nurses had all had the re-education completed by the Regional Quality Manager related to assessments, implementing the care plan, change of condition, documentation of PRN medications, and physician notification and the INTERACT process.<br><br>6. Materials and sign-in sheets, dated | F 281 | | |

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| F 281 | Continued From page 32<br>05/18/15-05/20/15, revealed the DON, ADON and Unit Managers re-educated all licensed staff on the same requirements with a competency test with a minimum score of 100% accuracy required. Staff interviews conducted on 05/28/15 with LPN #4 at 8:35 AM; LPN #5 at 8:51 AM; RN #2 at 10:12 AM; LPN #6 at 10:25 AM revealed the training had been completed and all the licensed staff had passed the test. On 05/18/15 through 05/20/15 all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse and notify the nurse of a change in condition and going up the chain of command. There were competency tests with a minimum score of 100% accuracy. Staff interviews on 05/28/15 with CNA #4 at 9:17 AM; CNA #5 at 9:25 AM; CNA #6 at 10:35 AM; and CNA #7 at 10:38 AM revealed the staff verified their training had been done and they had been tested regarding the care plans and notification of a change in condition.<br><br>7. Reviews of the every shift audits, dated 05/18/15 to 05/20/15, revealed the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents conditions each shift, to determine if licensed staff was notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. Interview with the DON, on 05/28/15 at 10:45 AM, revealed audits for residents' change of condition, notification of physician, and follow-up assessments were done on each shift until the AoC was accepted, and were now being done five times a week for twelve weeks. She | F 281 | | |

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| F 281 | Continued From page 33<br>stated the results of these audits will be reviewed in the QA Meetings.<br><br>8. Review of audits conducted by the DON, ADON or Unit Manager revealed five (5) residents' plans of care were reviewed to evaluate if interventions were in place and being followed.<br><br>9. Review of daily audits conducted by the DON, ADON, Unit Managers, or the MDS Coordinator revealed all narcotic records were audited daily, to identify any PRN pain medication administered and compared to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented.<br><br>10. A review of the QA meetings, dated 05/20/15, 05/21/15 and 05/22/15, revealed the agenda regarded concerns with the allegation deficiencies as well as the annual survey deficiencies, complaint, and facility self-reported complaints. The meeting was attended by the Administrator, DON, Activities Director, MDS Coordinator, Business Office Manager, Dietary Services Manager, Medical Records, Housekeeping and Maintenance and the Marketing Manager. Interview with the Medical Clinical Officer (MCO) revealed the Medical Director attended the 05/18/15 meeting, by phone and was kept abreast of any concerns and the meetings were to continue weekly, then monthly until resolved. | F 281 | | |
| F 282 SS=J | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility | F 282 | | |

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| F 282 | Continued From page 34<br>must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the hospital Consultation Reports and the facility's policies and procedures, it was determined the facility failed to provide services by qualified personnel according to the written plan of care for one (1) of three (3) sampled residents, (Resident #1.)<br><br>On 03/13/15, Resident #1 was noted to have a decline in cognition, weight bearing, transferring, continence, and verbalization after receiving two (2) as needed (PRN) medications, Lortab (for pain) and Ativan (for anxiety). Resident #1 needed the assistance of three (3) to transfer from the chair to the bed, was unable to eat his/her evening meal and staff was unable to wake up the resident. Staff and Resident #1's Spouse reported the changes to LPN #2 and they were told the resident was resting from the medications.<br><br>On the morning of 03/14/15, Resident #1's change in condition was reported to Licensed Practical Nurse (LPN) #1; and, on 03/14/15 at 8:37 AM, RN #1 identified Resident #1 was unresponsive. However, there was no documented evidence Resident #1's care plan was implemented related to the documentation of medications, monitoring the effectiveness and the side effects of the medications, monitoring for confusion and behaviors, conducting neurological assessments due to pharmacological factors and | F 282 | F282<br><br>1. Resident # 1 was discharged to the hospital on 05/06/2015 and did not return to the facility.<br>2. Beginning on 05/18/2015 and finishing on 05/19/2015 the DON, ADON, and Unit Managers and MDS Nurse reviewed all current resident's plans of care to determine if all interventions were being followed which included visual validation including physical assessment. Any identified interventions not in place were immediately put into place. On 06/03/2015 the Director of Nursing, Assistant Director of Nursing and Unit Managers conducted an observation of all current residents to determine if all residents were clean and well groomed to include nail care and oral care. No concerns were identified.<br>3. On 05/18/2015 the Regional Quality Manager re-educated with competency test the DON, ADON and Unit Managers,, MDS Nurse on the requirement to follow the plan of care and if the plan of care cannot be followed and an alternate is not within their scope of practice that the physician must be notified. Beginning 05/18/2015 and ongoing all license staff were re-educated on the requirement to follow the plan of care and if the plan of care cannot be followed and an alternate is not | |

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| F 282 | Continued From page 35<br>reporting to the physician, as needed.<br><br>On 03/14/15 at 11:00 AM, approximately eighteen (18) hours after the PRN medications were given, the resident was unresponsive and was sent out to the hospital, where it was determined the resident had a massive stroke. The resident was admitted to the Intensive Care Unit, was unresponsive, non-communicative, and required a Gastric Feeding Tube (GT), due to the inability to sustain nutrition.<br><br>The facility's failure to implement the care plan has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 05/18/15 and determined to exist on 03/13/15. An acceptable Allegation of Compliance (AoC) was received on 05/22/15, alleging the IJ was removed on 05/21/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/21/15, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.<br><br>The findings include:<br><br>Interview with the Regional Clinical Coordinator, on 05/18/15 at 6:15 PM, revealed there was no specific policy for care plans but the Interim Care Plans were generated on admission, based on the resident's diagnoses, history and Activities of Daily Living (ADL) needs, and concerns.<br><br>1. Closed record review revealed the facility admitted Resident #1 on 03/12/15 with diagnoses which included Morbid Obesity, Chronic Kidney | F 282 | within their scope of practice that the physician must be notified. This education was completed by the Director of Nursing, ADON, Unit Managers or MDS Nurse with competency test completed requiring 100% accuracy. No Licensed Nurse worked after 05/20/15 without having had this re-education and competency test. Beginning 05/18/2015 and ongoing all Certified Nursing Assistants were re-educated with competency test by the DON, ADPON, Unit managers or MDS Nurse related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after 05/20/2015 without having had this re-education and passing competency test with 100% accuracy. Beginning 06/04/2015 and ongoing the Director of Nursing, ADON or Unit Manager re-educated all Certified Nursing Assistants on cleanliness and hygiene including oral care and nail care. No Certified Nursing Assistant will work after 06/04/2015 without having had this re-education.<br><br>4. The DON, ADON or Unit Managers will review five (5) residents' plans of care weekly for twelve (12) weeks to determine if interventions are in place and being followed | |

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| F 282 | Continued From page 36<br>Disease Stage III, Anxiety State, Depressive Disorder, and Diabetes Mellitus.<br><br>Review of the Admission Data Set, dated 03/13/15, revealed the facility assessed the resident to be alert and oriented to person, place, and time, short and long term memory were intact, understood and understands with clear comprehension, was on a regular diabetic diet, was ambulatory with a walker, had no impairment in range of motion (ROM), and was continent of bowel and bladder.<br><br>Review of the Interim Plan of Care, dated 03/12/15, revealed interventions for staff to record the effectiveness of the pain medications, monitor and record the side effects of the medications, assess for pain as needed, report pain affecting daily life to the care provider, monitor the resident's blood sugars, monitor for confusion and behaviors and report to the physician, as needed. In addition, due to a fall at home and to "medical, neurological and pharmacological factors," there were interventions to implement neurological assessments, as needed.<br><br>Review of a Nursing Note, dated 03/13/15 at 2:53 PM, and interview with LPN #1 on 05/15/15 at 9:55 AM; and on 05/18/15 at 3:38 PM, revealed LPN #1 administered as needed (PRN) Lortab (pain) and Ativan (anxiety), on 03/13/15, at approximately 2:30 PM, for the resident's complaints of nervousness and chronic pain.<br><br>Interviews with Certified Nursing Assistant (CNA) #1, on 05/15/15 at 11:35 AM; CNA #2 on 05/15/15 at 11:40 AM; and, Resident #1's spouse on 05/12/15 at 9:50 AM and on 05/17/15 at 5:11 PM, revealed on 03/13/15 in the afternoon Resident | F 282 | including hygiene, oral care and nail care. The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly. | 06/05/15 |

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| F 282 | Continued From page 37<br>#1 was asleep in a chair and would not wake up. They stated the resident would not wake up for supper. CNA #1 stated he had to have two (2) ambulance attendants assist him to put the resident to bed because he/she was "dead weight". Resident #1's Spouse stated he/she informed the staff this was a change for the resident as he/she had never slept more than two (2) hours at a time due to all the pain from a previous fracture. CNA #1 and the Resident's Spouse were concerned with the resident's condition and they notified LPN #2 but were "assured it was due to the (PRN) medications."<br><br>Review of the Nurse's Notes, dated 03/13/15 and 03/14/15; and, review of the March 2015 Electronic Medication Administration Records (EMARs) revealed there was no documented evidence LPN #1 or LPN #2 assessed the resident to determine the effectiveness and/or side effects of the medications; assessed for any neurological changes in the resident; or monitored the resident for confusion and behaviors and reported to the physician, as stated in the plan of care.<br><br>Interview with LPN #1, on 05/15/15 at 9:55 AM; and, on 05/18/15 at 3:38 PM, revealed she was unsure why the results of the effectiveness of the PRNs were not documented and stated it had been a very busy week and she "probably forgot." The LPN was unable to remember if the resident had been assessed, prior to her leaving her shift at 6:00 PM. However, there was no documented evidence the resident was assessed.<br><br>Interview with LPN #2, on 05/15/15 at 11:10 AM; and, on 05/16/15 at 3:28 PM, revealed she worked the 6 PM - 6 AM shift, on 03/13/15. She | F 282 | | |

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| F 282 | Continued From page 38<br>stated the resident was sleeping and was never fully awakened, throughout the night. LPN #2 stated the resident was resting well from receiving the PRN medications and she felt there was no change in the resident's condition to require further assessment or warrant calling the physician. LPN #2 stated no one had told her that Resident #1 had experienced a change in condition.<br><br>Review of a Nursing Note, dated 03/14/15 at 8:47 AM, and interview with RN #1 on 05/15/15 at 8:25 PM and 10:40 AM; and, on 05/17/15 at 4:09 PM, revealed Resident #1 was unresponsive on 03/14/15, and he felt it was because the resident received pain medication prior to his shift. The RN stated he did an assessment of the resident at 8:47 AM and stated there was no facial drooping, yet the resident was unable to follow commands to stick out his/her tongue or grip hands. He stated he had to "hold the resident's eyes open" to assess the pupils, which were noted to have been "sluggish." The RN stated he was aware of the need to call the physician with any changes per the care plan, but he felt the need to get a second opinion on the resident's condition from another nurse (RN #2), who came to assess the resident at approximately 11:00 AM. He stated RN #2 administered two (2) sternal rubs on the resident and the process was begun to get the resident to the ER. The RN stated "looking back, I probably should have sent (him/her) out earlier."<br><br>Review of the Hospital Physician Consultation Reports, dated 03/14/15, revealed the resident was diagnosed with an Acute Cerebrovascular Accident (CVA-stroke). "TPA was not administered because the time the resident was | F 282 | | |

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| F 282 | Continued From page 39<br>last known well, was greater than three (3) hours prior to arrival." The resident was admitted to the Intensive Care Unit, was unresponsive, non-communicative, and required a Gastric Feeding Tube (GT), due to the inability to sustain nutrition.<br><br>Interview with the Director of Nursing (DON), on 05/18/15 at 5:30 PM, revealed there was no evidence the staff members followed the plan of care and ensured the resident was fully assessed after the PRN medications were were administered on 03/13/14 at 2:35 PM; and, after CNA #1 and the Resident's Spouse's concerns were made to the nurses.<br><br>Interview with the Administrator, on 05/18/15 at 5:05 PM, revealed staff should have assessed the resident and called the physician, when they first noticed the resident's change in cognition. He stated staff should have the followed the plan of care for the resident.<br><br>2. Record review revealed the facility readmitted Resident #1 on 03/27/15 with diagnoses which included Cerebrovascular Vascular Accident (CVA) and Dysphagia (swallowing difficulty) requiring the placement of a Gastrostomy Tube (G-Tube). The facility readmitted Resident #1 again, after a hospital stay on 04/10/15, due to leakage of fluids around the G-Tube site.<br><br>Review of the resident's Activity of Daily Living Plan of Care, dated 05/01/15, revealed the resident was unresponsive, totally dependent of staff for all care needs, NPO (nothing by mouth), and dependent on a Gastric Tube (GT) for all medications and nutrition and was incontinent of bowel and bladder. Review of the ADL plan of | F 282 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 282 | Continued From page 40<br>Care, dated 04/10/15, revealed nail care was to have been provided "as needed," and oral care was required "daily and PRN." Review of the care plan for "Impaired Skin Integrity," dated 04/28/15, revealed due to the "oral mucous membrane having a thick, brown film" and the resident breathing through the mouth and rarely closing the mouth," oral care was to have been provided "several times a day" and the resident was to only get bed baths, due to continuous tube feeding and treatment for a Sebaceous Cyst, at the back of his/ her head.<br><br>Review of the Physician Orders for April 2015 revealed staff was to assess the resident's finger and toenails every Friday on the 6 AM - 6 PM shift.<br><br>Interview with the hospital Certified Nurse Aide (CNA) #3, on 05/13/15 at 4:25 PM, revealed she was working in the Emergency Room (ER) at the hospital, when Resident #1 was admitted on 05/06/15. CNA #3 stated the resident presented to the ER with a foul odor, had fingernails with blackened debris under the nailbeds and was in need of mouth care, as the resident's oral cavity was full of a crusty, cake-like build-up that took "fourteen (14) pink swabs" to clean. The CNA also revealed there were dark rings on the sheets and stated the Director of Nursing (DON) at the nursing facility, had been called and made aware of the hospital's concerns with this resident.<br><br>Interview with hospital Registered Nurse (RN) #3, on 05/14/13 at 11:13 AM, revealed she was also working at the ER on 05/06/15, when Resident #1 was admitted. RN #3 stated the sheets had "old, dried urine rings around them and yet the resident had on a clean brief," his/her nails had | F 282 | | |

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| F 282 | Continued From page 41<br>"brown sediment packed under the nailbeds and dried blood on the fingertips, from what looked like Accu-checks," taken for blood sugar levels. The RN described the resident's mouth as having "caked-on debris in the roof" of the resident's mouth and noted "copious amounts of yellow, dried particles," as the resident's mouth was swabbed.<br><br>Review of the ER Physician's Clinical Report, dated 05/06/15, revealed the resident arrived at the ER at approximately 7:32 AM and the resident's chief complaint was green drainage "from all orifices," and report on arrival was the resident had "very poor mouth care with lots of oral secretions and also some mild drainage from around the GT site, but also appeared to have very poor local care around the GT."<br><br>Interviews, on 05/13/15 with CNA #8 at 1:25 PM and CNA #9 at 2:35 PM, revealed both CNAs stated the resident was bathed, mouth care was completed and the resident had clean sheets and a clean gown upon leaving the facility. CNA #8 stated she would clean the resident's mouth every time he/she was turned, approximately every two (2) hours and nail care was done with the bed bath. CNA #9 stated the resident received daily bed baths and mouth care was completed every hour and every time she went into the room, as the resident was a mouth breather and had the feeding tube and always had dried mucous in his/her mouth.<br><br>Interview with LPN #1, on 05/15/15 at 10:07 AM, revealed "it seemed like the more the CNAs cleaned (his/her) mouth, the more it needed cleaning." The LPN also stated the CNAs should be following the care plans and should be | F 282 | | |

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| F 282 | Continued From page 42<br>administering nail care each shift, when the bed bath was completed. The LPN monitored nail care during the weekly skin assessments. However, the resident's last skin assessment was completed on 05/01/15 and not due again, until 05/07/15. The resident was transported, per ambulance, to the hospital on 05/06/15.<br><br>Interview with RN #4, on 05/14/15 at 9:12 AM, revealed she assessed the resident prior to leaving the facility and did leave some of the bright green drainage around the resident's GT site "because I wanted them to see it." The RN stated she also assisted the CNAs to clean the resident, prior to transfer and stated he/she had a fresh gown and linens and stated the resident was a mouth breather and residents with this and a GT will have a "thrushy mouth". The RN stated the resident was a Full Code and she was afraid he/she had developed a "massive infection of some sort" and stated it did not take fifteen (15) minutes to get the resident out to the ER and she did not notice a problem with the fingernails. The RN stated she took the report from the hospital, and the hospital staff stated it took them over an hour to clean the resident up. The RN revealed she reported the call to the Director of Nursing (DON).<br><br>Interview with the DON, on 05/15/15 at 12:35 PM, revealed all residents' nails would be kept clean on a daily basis and trimmed as necessary and all nails would be trimmed by the nursing assistants except for the diabetic residents and their nails would be trimmed by the licensed nurse. The DON stated she would have expected the nail and mouth care to have been completed, as specified on the care plan. | F 282 | | |

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| F 282 | Continued From page 43<br>** The facility implemented the following actions to remove the Immediate Jeopardy:<br><br>1. Resident #1 no longer resides at the facility.<br><br>2. On 05/18/15, assessments were conducted for eighty-one (81) of eighty-one (81) current residents, to determine if there were any medical needs requiring physician notification that the physician was not already aware of. This assessment included vital signs, respiratory assessment, bowel sounds, and changes in level of consciousness. There were no identified residents with a change in condition that the physician was not aware of, or that required further physician notification.<br><br>3. The DON and ADON conducted an audit of all current residents, on 05/18/15, to identify any resident who had received an as needed (PRN) pain medication, in the past twenty four hours and to ensure that a follow up to the effectiveness or adverse side effects of the PRN pain medication was completed. There were no noted adverse side effects of any PRN pain and all had effect relief of pain and there were no identified residents with a change in condition that the physician was not aware of or requiring further physician notification.<br><br>4. On 05/18/15 through 05/19/15 the DON, ADON, Unit Managers and the MDS Coordinator reviewed all current residents' plans of care to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. On 05/18/15, the Regional Quality Manager re-educated the DON, ADON, Unit Managers for | F 282 | | |

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| F 282 | Continued From page 44<br>all three units (Units One (1), Two (2) and Three (3) and the MDS Coordinator on Physician Notification for a significant change in condition, based on the INTERACT program, developed under funding from CMS (Centers for Medicare and Medicare Services), to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a through assessment. Training also included conducting an assessment based on resident condition, follow up assessments as well as physician notification for a significant change condition, as well as utilizing the 911 system in an emergent situation. In addition, they were educated on the requirement to follow the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the physician must be notified. Competency tests were administered, to validate understanding and all received 100% accuracy.<br><br>6. On 05/18/15, all license staff was re-educated by the DON, ADON and Unit Managers Physician Notification for a significant change in condition, based on the INTERACT program, developed under funding from CMS, to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a through assessment. Training also included conducting an assessment based on resident condition, follow up assessments as well as physician notification for a significant change condition, as well as utilizing the 911 system in an emergent situation. In addition, they were educated on the requirement to follow the plan of | F 282 | | |

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| F 282 | Continued From page 45 | F 282 | | |

care, and if the plan of care cannot be followed and an alternative is not within their scope of practice that the physician must be notified. Competency tests were administered, to validate understanding and all received 100% accuracy. No licensed staff will work after 05/20/15 without having completed this re-education and competency test. All newly employed licensed nurses will receive this education prior to taking sole charge of a unit. On 05/18/15 and ongoing all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. In addition, re-education was provided related to reporting a change in condition to the Charge Nurse. If there are further concerns, the CNAs were then to report to the other nurse and up the chain of command. A competency test was administered to validate understanding with a minimum score of 100% accuracy and all CNAs passed with 100 % accuracy. No staff will work at the facility, after 05/20/15, without having this training and competency test with a minimum score of 100% accuracy, any staff not receiving 100% accuracy will be immediately re-educated and will not work until competency test is 100% accurate.

7. Beginning 05/18/15, the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents' conditions each shift, to determine if licensed staff were notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. This will continue on each shift including weekends until the Immediate Jeopardy is lifted, then five (5)

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| F 282 | Continued From page 46<br>times per week for twelve (12) weeks thereafter.<br><br>8. The DON, ADON or Unit Manager will review five (5) residents' plans of care per week for twelve (12) weeks to evaluate if interventions are in place and being followed. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee weekly until substantial compliance then monthly thereafter.<br><br>9. The DON, ADON, or Unit Managers, or the MDS Coordinator audited all narcotic records daily, to identify any PRN pain medication given and compare to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented, weekly including weekends, until the Immediate Jeopardy was lifted then five (5) times a week for twelve (12) weeks thereafter.<br><br>10. An Ad Hock Quality Assurance and Performance Improvement (QAPI) Committee was convened to review the facility investigation and concerns. An allegation of compliance was developed and reviewed with the Medical Director, who attended via phone. The results of all audits will be reviewed with the Quality Assurance and Improvement Committee weekly, until substantial compliance has been achieved, then monthly thereafter. The QAPI committee will meet weekly or anytime concerns are identified until substantial compliance, then monthly thereafter.<br><br>** The State Survey Agency validated the corrective actions taken by the facility as follows:<br><br>1. The resident no longer resides at the facility. | F 282 | | |

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| F 282 | Continued From page 47<br>2. Review of the 100% (81 of 81) resident assessments, dated 05/18/15, revealed the residents were assessed to determine if there were any medical needs to warrant physician notification with no concerns identified. Chart reviews were completed on Residents #4, #5 and #6 with no identified areas of concern.<br><br>3. Review of the DON and ADON conducted audits of all current residents, dated 05/18/15 to identify any resident that required a PRN medication and to ensure a follow-up assessment, monitoring for any side effect or reactions and to evaluate the effectiveness of the PRN, revealed they were completed without concerns.<br><br>4. Review of the audits dated 05/18/15 through 05/19/15 completed by the DON, ADON, Unit Managers and MDS Coordinator revealed all current residents' plans of care were reviewed to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. Materials and sign-in sheets, dated 05/18/15,were reviewed regarding in-services held by the Regional Quality Manager, for the Nursing Administration Staff and re-training on the EMAR system, documentation of PRN medications, physician notification, care planning and the INTERACT process were reviewed. Review of the Competency testing revealed staff had a 100% pass rate with no concerns noted. Interview with the DON, on 05/28/15 at 10:45 AM, revealed she and the Administrative Nurses had all had the re-education completed by the Regional Quality Manager related to assessments, implementing the care plan, | F 282 | | |

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| F 282 | Continued From page 48<br>change of condition, documentation of PRN medications, and physician notification and the INTERACT process.<br><br>6. Materials and sign-in sheets, dated 05/18/15-05/20/15, revealed the DON, ADON and Unit Managers re-educated all licensed staff on the same requirements with a competency test with a minimum score of 100% accuracy required. Staff interviews conducted on 05/28/15 with LPN #4 at 8:35 AM; LPN #5 at 8:51 AM; RN #2 at 10:12 AM; LPN #6 at 10:25 AM revealed the training had been completed and all the licensed staff had passed the test. On 05/18/15 through 05/20/15 all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse and notify the nurse of a change in condition and going up the chain of command. There were competency tests with a minimum score of 100% accuracy. Staff interviews on 05/28/15 with CNA #4 at 9:17 AM; CNA #5 at 9:25 AM; CNA #6 at 10:35 AM; and CNA #7 at 10:38 AM revealed the staff verified their training had been done and they had been tested regarding the care plans and notification of a change in condition.<br><br>7. Reviews of the every shift audits, dated 05/18/15 to 05/20/15, revealed the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents conditions each shift, to determine if licensed staff was notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. Interview with the DON, on 05/28/15 at | F 282 | | |

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| F 282 | Continued From page 49<br>10:45 AM, revealed audits for residents' change of condition, notification of physician, and follow-up assessments were done on each shift until the AoC was accepted, and were now being done five times a week for twelve weeks. She stated the results of these audits will be reviewed in the QA Meetings.<br><br>8. Review of audits conducted by the DON, ADON or Unit Manager revealed five (5) residents' plans of care were reviewed to evaluate if interventions were in place and being followed.<br><br>9. Review of daily audits conducted by the DON, ADON, Unit Managers, or the MDS Coordinator revealed all narcotic records were audited daily, to identify any PRN pain medication administered and compared to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented.<br><br>10. A review of the QA meetings, dated 05/20/15, 05/21/15 and 05/22/15, revealed the agenda regarded concerns with the allegation deficiencies as well as the annual survey deficiencies, complaint, and facility self-reported complaints. The meeting was attended by the Administrator, DON, Activities Director, MDS Coordinator, Business Office Manager, Dietary Services Manager, Medical Records, Housekeeping and Maintenance and the Marketing Manager. Interview with the Medical Clinical Officer (MCO) revealed the Medical Director attended the 05/18/15 meeting, by phone and was kept abreast of any concerns and the meetings were to continue weekly, then monthly until resolved. | F 282 | | |

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| F 309 SS=J | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the facility's policy and procedure, hospital Physician Consultation Reports, and "Lippincott Manual of Nursing Practice, Ninth Edition", it was determined the facility failed to ensure 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 for one (1) of three (3) sampled residents (Resident #1).<br><br>Resident #1 was reported to have exhibited declines in cognition, weight bearing, transferring, continence, and verbalization, beginning 03/13/15, after as needed (PRN) medications were administered. On 03/13/15, Resident #1's change in condition was reported to the Licensed Practical Nurse (LPN) #2; however, there was no documented evidence licensed staff had conducted an assessment related to the resident's decline. Resident #1 was admitted to the hospital, on 03/14/15, with diagnoses of Acute Mental Status Change and Acute Cerebrovascular Accident (CVA-stroke) was | F 309 | F309<br><br>1. Resident # 1 was discharged to the hospital on 05/06/2015 and di d not return to the facility.<br>2. On 05/18/2015 assessments were conducted for all current residents to determine if there were any medical needs requiring physician notification that the physician was not already aware of including vital signs, respiratory assessment, bowel sounds and changes in level of consciousness. This was completed by the Director of Nursing, Assistant Director of Nursing and | |

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| F 309 | Continued From page 51<br>transferred from the ER, to the Intensive Care Unit, unresponsive, non-communicative, and required a Gastric Feeding Tube (GT), due to the inability to sustain nutrition. The resident never regained the cognitive status or physical abilities held prior to the event and remained non-verbal, dependent on a Gastric Feeding Tube (GT) for nutritional support, incontinent and totally dependent on staff for all care needs.<br><br>The facility's failure to ensure 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 when a resident had a decline in intake and function has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/18/15 and determined to exist on 03/13/15. The facility was notified of the Immediate Jeopardy on 05/18/15. An acceptable Allegation of Compliance (AoC) was received on 05/22/15, alleging the removal of Immediate Jeopardy on 05/21/15 and the State Survey Agency validated the Immediate Jeopardy was removed on 05/28/15, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.<br><br>The findings include:<br><br>Review of the facility's policy for a Resident Change of Condition, undated, revealed the facility was to have notified the physician and family immediately, if there was a significant change of condition, regardless of the time. The | F 309 | Unit Managers. There were no concerns identified.<br>3. On 05/18/2015 the Regional Quality Manager re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers and MDS coordinator on physician notification for a significant change in condition based on the INTERACT program, developed under funding from CMS to prevent unnecessary acute care transfers to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a thorough assessment. Training included conducting an assessment based on resident condition with follow up assessments as well as physician notification and use of the 911 system in an emergent situation. Competency test were administered to validate understanding and all received 100% accuracy. Beginning 05/18/2015 and ongoing all licensed staff were re-educated b the DON, ADON and Unit Managers on physician notification for a significant change in condition based on the INTERACT program, developed under funding from CMS to prevent unnecessary acute care transfers to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing | |

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| F 309 | Continued From page 52<br>Nurse will use standards of clinical practice and the Interact III process to make this determination on immediacy.<br><br>Review of the Interact Communication Form used for guidance Before Calling the Physician, undated, required an assessment of the resident's Situation, Background, Appearance, and Review (SBAR Form) to have been utilized when the resident experienced a change of condition and prior to calling the physician. The staff was to have assessed the resident, observing the signs and symptoms the resident had experienced, checked the vital signs, reviewed recent progress notes, labs and etc., reviewed medication changes and alerts, evaluated the mental status, behaviors, respiratory, cardiovascular, abdominal, urine outputs, skin, pain, neurological and the Activities of Daily Living (ADLs) compared to the resident's baseline status as well as reviewing the resident's code status.<br><br>Interview with the Corporate Clinical Nursing Specialist, on 05/15/15 at 1:00 PM, revealed the facility had no policy for assessments but instead referred to the "Lippincott Manual of Nursing Practice, Ninth Edition," for guidance.<br><br>Review of the Clinical Manifestations for a stroke, Lippincott page 506, revealed signs and symptoms of a stroke included numbness, weakness or loss of motor ability, difficulty swallowing, aphasia of loss of speech, visual difficulties, altered cognitive abilities and self care deficits.<br><br>Record review revealed the facility admitted Resident #1 on 03/12/15 with diagnoses which | F 309 | a thorough assessment. Training included conducting an assessment based on resident condition with follow up assessments as well as physician notification and use of the 911 system in an emergent situation. Competency test were administered to validate understanding and all received 100% accuracy. No Licensed Nurse will work after 05/20/2015 without having received this re-education and pass competency test with 100% accuracy. Beginning 05/18/2015 all Nursing Assistants were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator related to reporting a change in condition to the Charge Nurse and if there are further concerns the CNA were then to report to the other nurses and up the chain of command . A competency test was administered with 100% accuracy. No Nursing Assistants will work after 05/20/2015 without having had this re-education and competency test.<br>4. Beginning 05/18/2015 the DON, ADON, MDS Coordinator or the Unit Managers will review with licensed nurses each shift all current residents conditions to determine if licensed staff were notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. This continued on each | |

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| F 309 | Continued From page 53<br>included Chronic Kidney Disease Stage III, Anxiety State, Hypertension, Diabetes Mellitus, Type II and a History of a Recent Back Surgery (Kyphoplasty at L2 and L3).<br><br>Review of the Admission Minimum Data Set assessment, dated 03/13/15, revealed the facility assessed Resident #1 as alert to person, place and time; had no long term or short term memory deficits, continent of bowel and bladder, on a regular diabetic diet with no chewing or swallowing difficulties, the resident's speech was understood and the resident understood others and had no limitations in range of movement.<br><br>Review of the Interim Plan of Care, dated 03/12/15, revealed interventions for staff to record the effectiveness of the pain medications; monitor and record the side effects of the medications, assess for pain, and to report pain affecting daily life, monitor the resident's blood sugars, monitor for confusion and behaviors and report to the physician, as needed. In addition, due to a fall at home and to "medical, neurological and pharmacological factors," there were interventions to implement neurological assessments, as needed.<br><br>Review of the Physician Orders, dated 03/12/15, revealed an order for Lortab five (5)/325 milligrams orally (mg) every six (6) hours PRN for pain and Ativan 0.5 mg orally four (4) times a day PRN for anxiety.<br><br>Review of the Nursing Notes, dated 03/13/15 at 2:53 PM, revealed Licensed Practical Nurse (LPN) #1 documented "the resident was awake and alert, with some confusion. Medicated times one for pain. Resident feeds self with tray set up. | F 309 | shift including weekends until removal of the Immediate Jeopardy then five times per week for twelve weeks thereafter. The DON, ADON or Unit Manager or MDS Coordinator will audit all narcotic records daily to identify any PRN pain medications given and compare to the Electronic Medical Record (EMAR) system to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented, This was completed daily until removal of the Immediate Jeopardy then completed five (5) times per week for twelve (12) weeks. Beginning 05/19/2015 the DON, ADON, or Unit Managers will review all nurses noted to determine if any significant change in condition has occurred without physician notification and that follow up assessment and documentation is occurring based on the clinical condition. This occurred daily including weekends until removal of the Immediate Jeopardy and then five (5) times per week for twelve weeks thereafter. The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality | |

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| F 309 | Continued From page 54<br>Appetite good. Fluids given with good results. Able to make wants and needs known. Resident is very needy and demanding. Continent of bowel and bladder. Feeds self with tray set up." However, review of the March 2015 Electronic Medication Administration Record revealed there was no documented evidence the medications had been administered and further review revealed there was no documented evidence in the EMAR or Nursing Notes that a follow-up assessment to determine the resident's response to the medications was conducted.<br><br>Interview with Certified Nursing Assistant (CNA) #1, on 05/15/15 at 11:35 AM, revealed he had worked with Resident #1 on 03/13/15, on the 2:30 PM - 10:30 PM shift and noticed a change in the resident, from the previous afternoon (03/12/15.) CNA #1 stated on 03/12/15, the resident had frequently requested the bedpan and was able to roll over on his/her side and hold to the side rail and able to ambulate with a walker, after assisting the resident out of the bed or chair. CNA #1 revealed on 03/13/15, the resident was "sleeping in a chair and would not wake up." The CNA stated he called on two (2) Emergency Medical Technicians (EMTs) who were in the building for another resident, to assist him to get the resident out of the chair as he/she was "dead weight," and unable to assist with standing or pivoting. He also stated the spouse was visiting and stated he/she had "never seen the resident like this." CNA #1 revealed vital signs were taken and were within the resident's normal range and the CNA informed the LPN #2 of his and the spouses' concerns and was "assured it was due to the (PRN) medications," that were administered at approximately 3:00 PM. | F 309 | Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly. | 06/05/15 |

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| F 309 | Continued From page 55<br>Interview with CNA #2, on 05/15/15 at 11:40 AM, revealed the CNA also worked the 2:30 PM - 10:30 PM shift on 03/13/15 and was told Resident #1 had just received PRN medication and the resident was up in a chair and "dozing off" at the start of the shift and the CNA stated she tried to wake the resident "just before supper," and the resident would not wake up or eat supper. The CNA stated the resident would open his/her eyes but go right back to sleep and had to be assisted back to bed and the resident had previously been able to transfer him/herself with a walker and the CNA "figured it was just the medication," and stated "nobody knew much about him/her."<br><br>Interview with Resident #1's Spouse, on 05/12/15 at 9:50 AM and 05/17/15 at 5:11 AM, revealed the spouse had visited the resident on 03/13/15 "after supper" and stated the resident never ate the supper meal. The spouse stated staff brought the tray in and sat it on the table and the food had not been touched when the staff came and picked the tray up. The spouse stated the resident "looked drugged out or over-medicated." The spouse also stated it took three (3) people to get the resident back in the bed that afternoon due to the resident being so lethargic. Further interview revealed the spouse revealed two (2) ambulance personnel were in the building and the male CNA asked them to help him get the resident back to bed because he/she was not bearing weight at all. The spouse stated he/she stayed until about 9:00 PM and the resident "looked like (he/she) was gone." The spouse revealed the resident had never had this type of reaction to the medication before and the resident never slept more than two (2) or three (3) hours at a time, because he/she was in so much pain all the time, from a spinal fracture in December | F 309 | | |

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| F 309 | Continued From page 56<br>2014. The spouse stated he/she told two (2) or three (3) staff members he was concerned, yet was unsure exactly who was told. He/She stated he/she felt they "should have gotten (the resident) out then." He requested they take the vital signs and was told they were fine and the resident was just resting from the PRN medication.<br><br>Interview with LPN #1, on 05/15/15 at 9:55 AM and 05/18/15 at 3:38 PM, revealed the LPN had worked the 6:00 AM - 6:00 PM shift on 03/13/15 when the resident had repetitive complaints regarding the sheets not fitting properly and requested to place the call light in different areas and stated this was the concern with the resident's "needy and demanding" behaviors, that were documented in the Nursing Notes. The LPN stated she had given Lortab five (5)/325 milligrams (mg) and Ativan 0.5 mg, as a PRN, on 03/13/15, at approximately 2:30 PM, for the resident's and the spouse's complaints of nervousness and chronic pain and this was the first time the LPN had administered these medications to the resident. The LPN was unsure as to why the results of the effectiveness of the PRNs were not documented, except that it had been a very busy week. She stated she went by the room at approximately 5:00 PM and the resident was "up in the chair talking and eating ." The LPN stated it was a busy day and was able to get help from RN #4, who was the Unit Manager.<br><br>Interview with RN #4, on 05/15/14 at 11:00 AM, revealed Resident #1 was a "little woozy" after receiving the PRNs on 03/13/15. She stated if she had been given those medications, she "would have been woozy too." The RN stated the resident was helped to bed and "went right to | F 309 | | |

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| F 309 | Continued From page 57<br>sleep," after having eaten the supper meal. However, review of the consumption records for the ADL documentation by the CNAs, dated 03/13/15-03/14/15 revealed the resident "refused" the dinner meal, on 03/13/15. The RN stated the results of the PRN should have been documented in the chart and EMARs.<br><br>Interview with LPN #2, on 05/15/15 at 11:10 AM and on 05/16/15 at 3:28 PM, revealed the LPN worked the 6:00 PM - 6:00 AM shift, on 03/13/15 and stated the resident was sleeping when the LPN made rounds at the start of her shift and the spouse was visiting at the bedside. LPN #2 stated the resident never fully awakened, throughout the night; however, he/she pulled his/her arm away when vital signs and accuchecks, (for blood sugar testing,) were administered. The LPN denied any report from CNAs or the family regarding any concerns with the resident and felt the resident was resting well from receiving the PRN medications, as the vital signs and blood sugar levels were within the resident's normal levels and felt there was need for further assessments. However, review of March 2015 EMARS revealed the blood sugar was initialed but there was no evidence the results had been documented.<br><br>Review of Nursing Notes documented by Registered Nurse (RN) #1, dated 03/14/15 at 8:47 AM, revealed "Resident has been very unresponsive, I believe this to be because he/she had received pain medication prior to my shift, according to report, he/she does not react particularly well" and has "sluggish pupil constriction." The next entry, made by RN #1, on 03/14/15 at 11:36 AM, revealed the resident was unresponsive to two sternal rubs and sent to the | F 309 | | |

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| F 309 | Continued From page 58<br>Emergency Room (ER) at 11:34 AM.<br><br>Review of the Hospital Physician Consultation Reports, dated 03/14/15, revealed the Attending Physician's clinical impression was a "non-traumatic cerebrovascular accident involving a distal branch of the posterior cerebral artery. TPA was not administered because the time the patient was last known well, was greater than three hours prior to arrival."<br><br>Interview with RN #1, on 05/15/15 at 8:25 PM and 10:40 AM and 05/17/15 at 4:09 PM, revealed he worked the 6:00 AM - 6:00 PM shift on 03/14/15 and the Resident #1 was "mostly unresponsive" when he started his shift at 6:00 AM and remained that way, until sent to the ER at 11:34 AM. He stated on 03/14/15 at approximately 8:00 AM, he had taken the resident's Pulse Oximeter reading (used to measure the oxygen saturation of the blood) and this was 96 percent, with a heart rate of 109 and the RN stated he felt he had a "window of time to work in" and he felt the PRN medications were "still hanging around." The RN made an entry into the Nursing Notes at 8:47 AM and he had "checked in on (him/her) several times" and stated there was no facial drooping, yet the resident was unable to follow commands to stick out his/her tongue or grip the RN's hands, to test for grip strength and stated he had to "hold (his/her) eyes open" to assess the pupils, which were noted to have been "sluggish." Vital signs were not taken at that time but he/she did obtain them prior to sending the resident to the hospital at 11:34 AM. The RN stated he started working on the SBAR tool, for guidance at 9:00 AM and noted the resident was "drowsy and lethargic" at that time. He stated he had graduated from RN school five (5)months ago and felt the need to get | F 309 | | |

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| F 309 | Continued From page 59 | F 309 | | |

a second opinion on the resident's condition from another nurse working at the time. RN #2 came to assess the resident at approximately 11:00 AM, administered two sternal rubs on the resident and the process was begun to get the resident to the ER, the spouse and physician were called and the resident left the facility at 11:34 AM. The RN stated "looking back, I probably should have sent (him/her) out earlier."

Interview with RN #2, on 05/14/15 at 9:15 AM, revealed she was not the resident's assigned nurse on 03/14/15, but was working another area, at approximately 11:00 AM, when RN #1 asked her to come and take a look at the resident. The RN stated the resident was not responsive to sternal rubs and she assisted the staff to get the resident to the ER, as the resident was a Full Code.

Interview with the Director of Nursing (DON), on 05/18/15 at 5:30 PM, revealed she was on a medical leave of absence during this time and felt if the LPN had entered the PRN medications into the EMAR, there would have been an automatic pop up to remind the nurse the follow- up assessment was due, regarding the effectiveness or possible side-effects of the PRN medications. However, this was not done, there was no evidence the resident was fully assessed after the PRN, after concerns from CNA #1 and the spouses concerns were made and prior to having unresponsiveness to two sternal rubs and being sent to the ER.

Interview with the Assistant Director of Nursing (ADON), on 05/18/15 at 6:00 PM, revealed she also had medical issues during this time frame and had to be out of the facility, but would have

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| F 309 | Continued From page 60<br>expected the staff to have assessed the resident and called the physician with any change of condition.<br><br>Interview with the Administrator, on 05/18/15 at 5:05 PM, revealed the Administrator had been made aware of the resident having been administered the PRNs, although she was unsure when and stated she talked to the spouse, who stated the resident had been having a difficult time sleeping and was glad the resident was finally getting some rest. However, she stated the staff should have assessed the resident and called the physician, when they first noticed the change in mentation.<br><br>Interview with the Resident #1's attending physician at the facility, on 05/15/15 at 12:16 PM, revealed "if the resident was drowsy, early on after administration of the medications was not unusual" and stated "it was not concerning whether or not they had called me at 8:30 AM or 11:30 AM as 90 percent (%) of strokes occur while sleeping. You have to look back to the last time the resident was normal before an acute intervention, as TPA, (Tissue Plasminogen Activator, a medication given to break down blood clots) could have been administered effectively and this has to be within the three hour window of time, from the last resident's normal."<br><br>** The facility implemented the following actions to remove the Immediate Jeopardy:<br><br>1. Resident #1 no longer resides at the facility.<br><br>2. On 05/18/15, assessments were conducted for eighty-one (81) of eighty-one (81) current residents, to determine if there were any medical | F 309 | | |

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| F 309 | Continued From page 61<br>needs requiring physician notification that the physician was not already aware of. This assessment included vital signs, respiratory assessment, bowel sounds, and changes in level of consciousness. There were no identified residents with a change in condition that the physician was not aware of, or that required further physician notification.<br><br>3. The DON and ADON conducted an audit of all current residents, on 05/18/15, to identify any resident who had received an as needed (PRN) pain medication, in the past twenty four hours and to ensure that a follow up to the effectiveness or adverse side effects of the PRN pain medication was completed. There were no noted adverse side effects of any PRN pain and all had effect relief of pain and there were no identified residents with a change in condition that the physician was not aware of or requiring further physician notification.<br><br>4. On 05/18/15 through 05/19/15 the DON, ADON, Unit Managers and the MDS Coordinator reviewed all current residents' plans of care to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. On 05/18/15, the Regional Quality Manager re-educated the DON, ADON, Unit Managers for all three units (Units One (1), Two (2) and Three (3) and the MDS Coordinator on Physician Notification for a significant change in condition, based on the INTERACT program, developed under funding from CMS (Centers for Medicare and Medicare Services), to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care | F 309 | | |

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| F 309 | Continued From page 62<br>paths for certain common symptoms to help guide assessment and assist in completing a through assessment. Training also included conducting an assessment based on resident condition, follow up assessments as well as physician notification for a significant change condition, as well as utilizing the 911 system in an emergent situation. In addition, they were educated on the requirement to follow the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the physician must be notified. Competency tests were administered, to validate understanding and all received 100% accuracy.<br><br>6. On 05/18/15, all license staff was re-educated by the DON, ADON and Unit Managers Physician Notification for a significant change in condition, based on the INTERACT program, developed under funding from CMS, to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a through assessment. Training also included conducting an assessment based on resident condition, follow up assessments as well as physician notification for a significant change condition, as well as utilizing the 911 system in an emergent situation. In addition, they were educated on the requirement to follow the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice that the physician must be notified. Competency tests were administered, to validate understanding and all received 100% accuracy. No licensed staff will work after 05/20/15 without having completed this re-education and competency test. All newly employed licensed | F 309 | | |

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| F 309 | Continued From page 63<br>nurses will receive this education prior to taking sole charge of a unit. On 05/18/15 and ongoing all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. In addition, re-education was provided related to reporting a change in condition to the Charge Nurse. If there are further concerns, the CNAs were then to report to the other nurse and up the chain of command. A competency test was administered to validate understanding with a minimum score of 100% accuracy and all CNAs passed with 100 % accuracy. No staff will work at the facility, after 05/20/15, without having this training and competency test with a minimum score of 100% accuracy, any staff not receiving 100% accuracy will be immediately re-educated and will not work until competency test is 100% accurate.<br><br>7. Beginning 05/18/15, the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents' conditions each shift, to determine if licensed staff were notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. This will continue on each shift including weekends until the Immediate Jeopardy is lifted, then five (5) times per week for twelve (12) weeks thereafter.<br><br>8. The DON, ADON or Unit Manager will review five (5) residents' plans of care per week for twelve (12) weeks to evaluate if interventions are in place and being followed. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee weekly until | F 309 | | |

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| F 309 | Continued From page 64<br>substantial compliance then monthly thereafter.<br><br>9. The DON, ADON, or Unit Managers, or the MDS Coordinator audited all narcotic records daily, to identify any PRN pain medication given and compare to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented, weekly including weekends, until the Immediate Jeopardy was lifted then five (5) times a week for twelve (12) weeks thereafter.<br><br>10. An Ad Hock Quality Assurance and Performance Improvement (QAPI) Committee was convened to review the facility investigation and concerns. An allegation of compliance was developed and reviewed with the Medical Director, who attended via phone. The results of all audits will be reviewed with the Quality Assurance and Improvement Committee weekly, until substantial compliance has been achieved, then monthly thereafter. The QAPI committee will meet weekly or anytime concerns are identified until substantial compliance, then monthly thereafter.<br><br>** The State Survey Agency validated the corrective actions taken by the facility as follows:<br><br>1. The resident no longer resides at the facility.<br><br>2. Review of the 100% (81 of 81) resident assessments, dated 05/18/15, revealed the residents were assessed to determine if there were any medical needs to warrant physician notification with no concerns identified. Chart reviews were completed on Residents #4, #5 and #6 with no identified areas of concern. | F 309 | | |

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| F 309 | Continued From page 65<br>3. Review of the DON and ADON conducted audits of all current residents, dated 05/18/15 to identify any resident that required a PRN medication and to ensure a follow-up assessment, monitoring for any side effect or reactions and to evaluate the effectiveness of the PRN, revealed they were completed without concerns.<br><br>4. Review of the audits dated 05/18/15 through 05/19/15 completed by the DON, ADON, Unit Managers and MDS Coordinator revealed all current residents' plans of care were reviewed to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. Materials and sign-in sheets, dated 05/18/15,were reviewed regarding in-services held by the Regional Quality Manager, for the Nursing Administration Staff and re-training on the EMAR system, documentation of PRN medications, physician notification, care planning and the INTERACT process were reviewed. Review of the Competency testing revealed staff had a 100% pass rate with no concerns noted. Interview with the DON, on 05/28/15 at 10:45 AM, revealed she and the Administrative Nurses had all had the re-education completed by the Regional Quality Manager related to assessments, implementing the care plan, change of condition, documentation of PRN medications, and physician notification and the INTERACT process.<br><br>6. Materials and sign-in sheets, dated 05/18/15-05/20/15, revealed the DON, ADON and Unit Managers re-educated all licensed staff on the same requirements with a competency test | F 309 | | |

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| F 309 | Continued From page 66<br>with a minimum score of 100% accuracy required. Staff interviews conducted on 05/28/15 with LPN #4 at 8:35 AM; LPN #5 at 8:51 AM; RN #2 at 10:12 AM; LPN #6 at 10:25 AM revealed the training had been completed and all the licensed staff had passed the test. On 05/18/15 through 05/20/15 all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse and notify the nurse of a change in condition and going up the chain of command. There were competency tests with a minimum score of 100% accuracy. Staff interviews on 05/28/15 with CNA #4 at 9:17 AM; CNA #5 at 9:25 AM; CNA #6 at 10:35 AM; and CNA #7 at 10:38 AM revealed the staff verified their training had been done and they had been tested regarding the care plans and notification of a change in condition.<br><br>7. Reviews of the every shift audits, dated 05/18/15 to 05/20/15, revealed the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents conditions each shift, to determine if licensed staff was notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. Interview with the DON, on 05/28/15 at 10:45 AM, revealed audits for residents' change of condition, notification of physician, and follow-up assessments were done on each shift until the AoC was accepted, and were now being done five times a week for twelve weeks. She stated the results of these audits will be reviewed in the QA Meetings. | F 309 | | |

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| F 309 | Continued From page 67<br>8. Review of audits conducted by the DON, ADON or Unit Manager revealed five (5) residents' plans of care were reviewed to evaluate if interventions were in place and being followed.<br><br>9. Review of daily audits conducted by the DON, ADON, Unit Managers, or the MDS Coordinator revealed all narcotic records were audited daily, to identify any PRN pain medication administered and compared to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented.<br><br>10. A review of the QA meetings, dated 05/20/15, 05/21/15 and 05/22/15, revealed the agenda regarded concerns with the allegation deficiencies as well as the annual survey deficiencies, complaint, and facility self-reported complaints. The meeting was attended by the Administrator, DON, Activities Director, MDS Coordinator, Business Office Manager, Dietary Services Manager, Medical Records, Housekeeping and Maintenance and the Marketing Manager. Interview with the Medical Clinical Officer (MCO) revealed the Medical Director attended the 05/18/15 meeting, by phone and was kept abreast of any concerns and the meetings were to continue weekly, then monthly until resolved. | F 309 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. | F 312 | | |

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| F 312 | Continued From page 68<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and facility policy review, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Residents #1), who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain grooming, and personal and oral hygiene. The facility failed to provide oral hygiene and nail care for Resident #1, prior to sending the resident to the hospital, for evaluation of a change of consciousness.<br><br>The findings include:<br><br>Review of the facility Certified Nurse Aide (CNA) training materials from "Lippincott's Textbook for Nursing Assistants," undated, revealed mouth care was to have been provided upon awakening, after meals and before bed. A resident who is unconscious needs frequent mouth care, due to mouth breathing, which causes secretions to thicken and dry on the lips and mouth. The staff was to have kept the resident's mucous membranes of the mouth moist and healthy.<br><br>Interview with the Director of Nursing (DON), on 05/15/15 at 12:35 PM, revealed all residents' nails would be kept clean on a daily basis and trimmed as necessary and all nails would be trimmed by the nursing assistants except for the diabetic residents and their nails would be trimmed by the licensed nurse.<br><br>Closed record review revealed the facility readmitted Resident #1 on 03/27/15 with | F 312 | F312<br>1. Resident # 1 was discharged to the hospital on 05/06/2015 and did not return to the facility.<br>2. On 06/03/2015 the Director of Nursing, Assistant Director of Nursing and Unit Managers conducted an observation of all current residents to determine if all residents were clean and well groomed to include nail care and oral care. No concerns were identified.<br>3. By 06/04/2015 the Director of Nursing, ADON or Unit Manager re-educated all Certified Nursing Assistants on cleanliness and hygiene including oral care and nail care. No Certified Nursing Assistant will work after 06/04/2015 without having had this re-education.<br>4. The DON, ADON, or Unit Manager will observe five (5) resident per week for twelve (12) weeks to ensure residents are clean and groomed including oral care and nail care. The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist | |

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| F 312 | Continued From page 69<br>diagnoses which included Cerebrovascular Vascular Accident and Dysphagia (swallowing difficulty) requiring the placement of a Gastrostomy Tube (G-Tube). The resident was readmitted again to the facility, after a hospital stay on 04/10/15, due to leakage of fluids around the G-Tube site.<br><br>Review of the Physician Orders for April 2015 revealed the staff was to have assessed the resident's finger and toenails every Friday on the 6 AM- 6 PM shift.<br><br>Review of the resident's Activity of Daily Living (ADL) Plan of Care, dated 05/01/15, revealed the resident was unresponsive, totally dependent on staff for all care needs, NPO (nothing by mouth), and dependent on GT tube (feeding tube) for all medications and nutrition and the resident was incontinent of bowel and bladder. Review of the ADL Plan of Care, dated 04/10/15, revealed nail care was to have been provided "as needed," and oral care was required "daily and PRN."<br><br>Further record review revealed Resident #1 was sent to the hospital on 05/06/15 (Wednesday) at approximately 7:40 AM for a possible infection from the GT site and did not return to the facility.<br><br>Interview with the hospital Certified Nurse Aide (CNA) #3, on 05/13/15 at 4:25 PM, revealed she was working in the Emergency Room (ER) at the hospital when Resident #1 was admitted on 05/06/15. CNA #3 stated the resident presented to the ER with a foul odor, had fingernails with blackened debris under the nailbeds and was in need of mouth care, as the oral cavity was full of a crusty, cake-like build-up that took "fourteen (14) pink swabs" to clean. The CNA also stated | F 312 | of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly. | 06/05/15 |

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| F 312 | Continued From page 70 | F 312 | | |

there were dark rings on the sheets. CNA #3 stated the Director of Nursing (DON) at the facility had been called and made aware of the hospital's concerns with this resident.

Interview with hospital Registered Nurse (RN) #3, on 05/14/13 at 11:13 AM, revealed she was also working at the ER on 05/06/15, when Resident #1 was admitted. RN #3 stated the sheets had "old, dried urine rings around them", his/her nails had "brown sediment packed under the nailbeds and dried blood on the fingertips, from what looked like Accu-checks," taken for blood sugar levels. RN #3 described the resident's mouth as having "caked-on debris in the roof" of the resident's mouth and noted "copious amounts of yellow, dried particles" as the resident's mouth was swabbed. The RN stated the DON was called, as a courtesy, and she did come to the ER to assess the resident and talked to some of the staff working at the hospital.

Review of the ER Physician's Clinical Report, dated 05/06/15, revealed the resident arrived at the ER at approximately 7:32 AM and the resident's chief complaint was green drainage "from all orifices," and report on arrival was the resident had very poor mouth care with lots of oral secretions and also some mild drainage from around the GT site but also appeared to have very poor local care around the GT."

Interviews on 05/13/15 with CNA #8 at 1:25 PM and CNA #9 at 2:35 PM, revealed both CNAs stated the resident was being turned for incontinent care on the morning of 05/06/14 and was rolled over to the side and a greenish fluid started coming out of the resident's mouth, GT site and rectum and both CNAs stated this had

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| F 312 | Continued From page 71<br>never occurred with this resident before. The CNAs stated RN #4 was called and assessed the resident and he/she was immediately sent out to the hospital. Both CNAs stated the resident was bathed, mouth care was completed and the resident had clean sheets and a clean gown upon leaving the facility. CNA #8 stated she would clean the resident's mouth every time he/she was turned, approximately every two hours and nail care was done with the bed bath. CNA #9 stated the resident received daily bed baths and mouth care was completed every hour and every time she went into the room, as the resident was a mouth breather and had the feeding tube and always had dried mucous in his/her mouth.<br><br>Interview with LPN #1, on 05/15/15 at 10:07 AM, regarding mouth care revealed "it seemed like the more the CNAs cleaned (his/her) mouth, the more it needed cleaning." The LPN also stated the CNAs should be completing nail care each shift, when the bed bath was completed and the LPN monitored this during the weekly skin assessments. However, the resident's last skin assessment was completed on 05/01/15 and not due again, until 05/07/15. The resident was transported, per ambulance, to the hospital on 05/06/15.<br><br>Interview with RN #4, on 05/14/15 at 9:12 AM, revealed she assessed the resident prior to leaving the facility and did leave some of the bright green drainage around the resident's GT site "because I wanted them to see it." The RN stated she also assisted the CNAs to clean the resident, prior to transfer and stated he/she had a fresh gown and linens and stated the resident was a mouth breather and resident's with this and a GT will have a "thrushy mouth". RN #4 stated | F 312 | | |

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| F 312 | Continued From page 72<br>the resident was a Full Code and she was afraid he/she had developed a "massive infection of some sort" and stated it did not take fifteen (15) minutes to get the resident out to the ER and she did not notice a problem with the fingernails. The RN stated she took the report, from the hospital and the hospital staff stated it took them over an hour to clean the resident up. The RN revealed she reported the call to the Director of Nursing (DON.)<br><br>Interview with the DON, on 05/15/15 at 12:35 PM, revealed the DON was notified of the hospital concerns and went to the hospital to assess the resident's condition. The DON stated hospital RN #3 had left two (2) or three (3) "dirty nails for me to see". The DON revealed the reason the resident went to the hospital was due to the foul odor and drainage. The DON stated she did an investigation when she returned to the facility and stated in an emergency situation, the important thing was to get the resident out of the facility, clean, "but nails-not so much." The DON stated she talked to the CNAs, who took care of the resident on 05/06/15 revealed the CNAs stated the sheets had been changed and the resident was known to have fidgeted with scratching motions on his/her skin, as why there was debris under the nails, yet there was no indication of any scratch marks on the skin with a review of the skin assessments or from the staff interviews and the DON stated she would have expected the nail care to have been done.<br><br>Interview with Resident #1's attending physician at the facility, on 05/13/15 at 1:48 PM, revealed the resident had experienced a massive stroke in March 2015 and had been unresponsive since, requiring a GT for nutrition, albeit the GT never | F 312 | | |

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| F 312 | Continued From page 73<br>really functioned for this resident due to the resident having such a massive stroke, there was "not enough gastric motility to make the GT work." The greenish fluid was bile mixed with the GT feeding, that never really was absorbed by the resident's stomach and the smell was due to the bile. | F 312 | | |
| F 514 SS=J | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to maintain clinical records that were complete and accurately documented for one (1) of three (3) sampled residents (Resident #1), related to incomplete documentation of Electronic Medication Administration Records (EMARs), assessments, accuchecks and services provided. | F 514 | F514<br><br>1. Resident # 1 was discharged to the hospital on 05-06-2015 and did not return to the facility.<br>2. On 05/18/2015 the Director of Nursing and Assistant Director of Nursing conducted an audit of all current resident to identify any resident who had received an as needed (PRN) pain medication in the past twenty four hours and to ensure that a follow up to the effectiveness or adverse side effects of the PRN pain medication was completed. There were no noted adverse side effects of any PRN pain medications and all had effective relief of pain. 2. On 05/18/2015 assessments were conducted for all current residents to | |

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| F 514 | Continued From page 74<br><br>The facility failed to document in the clinical record the "as needed" medications administered to Resident #1 on 03/13/15; failed to document the results and effectiveness of the PRN medications on the Electronic Medication Administration Record or in the clinical record; failed to ensure two narcotics, Lortab and Ativan were signed out properly on the Narcotic Count Sheet; failed to document the results of blood sugars taken on 03/13/15; and, failed to document the order for the accuchecks accurately as it was ordered to obtain blood sugars three (3) times a day (TID) and to obtain blood sugars four (4) times a day (QID) on the EMARs. Review of the physician's order, dated 03/12/15, revealed "accuchecks before meals (AC) and at bedtime (HS)".<br><br>The facility's failure to document narcotics administered in the EMARs, failure to document and complete a follow-up assessment, and failure to accurately document and assess Resident #1's condition, for approximately 18 hours, after medication administration, resulting in the failure of the resident being treated with clot busting medications, during the three hour window of time needed. The facility failed to maintain clinical records that were complete and accurately documented caused, or was likely to cause, serious injury, harm, impairment or death of a resident. Immediate Jeopardy was identified on 05/18/15 and determined to exist on 03/13/15. The facility was notified of the Immediate Jeopardy on 05/18/15.<br><br>The findings include:<br><br>Review of the facility's policy and procedure titled, | F 514 | determine if there were any medical needs requiring physician notification that the physician was not already aware of including vital signs, respiratory assessment, bowel sounds and changes in level of consciousness. This was completed by the Director of Nursing, Assistant Director of Nursing and Unit Managers. There were no concerns identified. On 05/08/15 the DON and ADON conducted an audit of all current resident's orders to determine if there was an order for accuchecks that it was in Emar correctly and results were being documented. No concerns were identified.<br>3. On 05/18/2015 the Regional Quality Manager re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers and MDS coordinator on physician notification for a significant change in condition including documentation based on the INTERACT program, developed under funding from CMS to prevent unnecessary acute care transfers to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a thorough assessment. Training included conducting an assessment based on resident condition with follow up assessments as well as physician notification and use of the 911 | |

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| F 514 | Continued From page 75<br>"Medication Administration," undated, revealed the staff were required to "indicate the reason for the administration and effectiveness of PRN medication in the chart, on the back of the MAR.<br><br>Review of the facility "Guidelines for Nursing Care, Clinical Quality Assessment Performance Improvement (QAPI) Daily Review Process," dated 08/01/14, revealed the purpose was to ensure the admission charts/ readmission charts; physician orders, incident reports, infections, labs, 24 hour reports, Accu-nurse Alerts, Situation, Background, Appearance and Review (SBAR) from the previous day (or week-end, if on Monday morning), are to be reviewed for completion and follow-up in the Clinical Daily Review Meeting.<br><br>Record review revealed the facility admitted Resident #1 on 03/12/15 with diagnoses which included Morbid Obesity, Chronic Kidney Disease Stage III, Anxiety State, Depressive Disorder, and Diabetes Mellitus.<br><br>Review of the Physician Orders, dated 03/12/15, revealed as needed (PRN) orders for Ativan 0.5 milligrams (mg) orally, four times daily for anxiety; Lortab five (5)/325 mg tablet orally every six (6) hours for pain; and, Accu-checks (to assess blood sugars) four (4) times a day, before meals and at bedtime. Review of the Admission/ Readmission Checklist, dated 03/12/15, revealed the medication orders were verified and signed off by two (2) nurses.<br><br>Review of the Nursing Notes, dated 03/13/15 at 2:53 PM, revealed Licensed Practical Nurse (LPN) #1 administered medication for pain and the resident was "awake and alert, with some | F 514 | system in an emergent situation. And documentation of using a SBAR or Nurses Note. Training included documentation of follow up assessment for effectiveness and adverse side effects as well as accuchecks in the emar system. A Competency test were administered to validate understanding and all received 100% accuracy. Beginning 05/18/2015 and ongoing all licensed staff were re-educated b the DON, ADON and Unit Managers on physician notification including documentation for a significant change in condition based on the INTERACT program, developed under funding from CMS to prevent unnecessary acute care transfers to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms to help guide assessment and assist in completing a thorough assessment. Training included conducting an assessment based on resident condition with follow up assessments as well as physician notification and documentation in the nurses note or SBAR and use of the 911 system in an emergent situation. Training included documentation of accuchecks in the emar system. Competency test were administered to validate understanding and all received 100% accuracy. No Licensed Nurse will work after 05/20/2015 without having received this re-education | |

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| F 514 | Continued From page 76<br>confusion".<br><br>Review of the "Controlled Substance Proof" Records for PRN Ativan and Lortab for Resident #1 revealed these medications were administered on 04/13/15 at 2:35 PM and there was no documented evidence they were administered on 03/13/15 at 2:53 PM.<br><br>Review of Resident #1's EMARs, for 03/13/15 revealed there was no documentation Lortab or Ativan had been administered to Resident #1 on 03/13/15 at approximately 2:35 PM or a follow-up assessment was conducted to determine the effectiveness of the PRN medications. In addition, further review of the Nursing Notes, revealed there was no documented evidence the resident was assessed for the effectiveness of the medication<br><br>Hospital record review and interview with Licensed Practical Nurse (LPN) #1, on 05/15/15 at 10:40 AM, revealed the resident was in the hospital on 04/13/15. LPN #1 stated she should have dated the Ativan and Lortab as administered on 03/13/15 at 2:35 PM, instead of 04/13/15 at 2:35 PM. LPN #1 stated she did not know why the effectiveness of the medication was not documented but it was a busy day and Registered Nurse (RN) #4 helped her that day.<br><br>Interview with RN #4, on 05/15/14 at 11:13 AM, revealed the results of the PRN should have been documented in Resident #1's chart and EMARs. RN #4 stated she assisted with chart audits; however, she did not check the nurses' documentation in the chart.<br><br>Interview with the Resident #1's Family Member, | F 514 | and pass competency test with 100% accuracy. Beginning 05/18/2015 all Nursing Assistants were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator related to reporting a change in condition to the Charge Nurse and if there are further concerns the CNA were then to report to the other nurses and up the chain of command . A competency test was administered with 100% accuracy. No Nursing Assistants will work after 05/20/2015 without having had this re-education and competency test.<br>4. Beginning 05/18/2015 the DON, ADON, MDS Coordinator or the Unit Managers will review with licensed nurses each shift all current residents conditions to determine if licensed staff were notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. This continued on each shift including weekends until removal of the Immediate Jeopardy then five times per week for twelve weeks thereafter. The DON, ADON or Unit Manager or MDS Coordinator will audit all Medication Administration records daily to identify any PRN pain medications given and compare to the Electronic Medical Record (EMAR) system to validate that follow up to effectiveness and | |

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| F 514 | Continued From page 77<br>on 05/17/15 at 5:11 PM revealed on 03/13/15, after the supper meal, a nurse came into the resident's room to check the resident's blood sugar and found it to be "600." The family member asked what the staff was going to do and was told they were "going to give the insulin."<br><br>Further review of the March 2015 EMARs revealed there were two (2) different entries for Accu-checks, one for three (3) times a day and one for four (4) times a day even though there was no physician's order to obtain blood sugar levels three times a day. In addition, there was an order to administer Humalog (insulin) 10 units SQ every day before each meal, at 6:30 AM; 1:00 PM and 6:00 PM and Lantus (insulin) 30 units SQ at bedtime.<br><br>Review of the March 2015 EMARs revealed there were initials indicating Accu-checks were completed four (4) times a day on 03/13/15, Humalog 10 mg was administered before each meal and Lantus 30 units was administered at bedtime (9:00 PM) on 03/13/15. However, there was no documentation of the resident's blood sugar readings that were conducted four times a day on 03/13/15.<br><br>Review of the consumption records for the Activities of Daily Living (ADL) documentation by the CNAs, dated 03/13/15-03/14/15 revealed the resident "refused" the supper meal on 03/13/15 and the breakfast meal was "not consumed" on 03/14/15.<br><br>Interviews on 05/15/15 with LPN #1 at 9:55 AM, LPN #2 at 11:10 AM, RN #1 at 8:25 AM and RN #4 at 11:00 AM, revealed there was a computer glitch that prevented the EMAR from recording | F 514 | adverse side effects of PRN medications was documented, This was completed daily until removal of the Immediate Jeopardy then completed five (5) times per week for twelve (12) weeks. Beginning 05/19/2015 the DON, ADON, or Unit Managers will review all nurses noted to determine if any significant change in condition has occurred without physician notification and that follow up assessment and documentation is occurring based on the clinical condition. This occurred daily including weekends until removal of the Immediate Jeopardy and then five (5) times per week for twelve weeks thereafter. The DON, ADON, Unit Manager or MDS Nurse will review accuchecks twice a month for three months to ensure results are documented. The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the | |

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| F 514 | Continued From page 78<br>the blood sugar readings, taken on 03/13/15. The RNs and LPNs stated the resident should have eaten the supper meal before the insulin was administered and stated if the blood sugars were over 400, the physician would have been called.<br><br>Interview with the Director of Nursing (DON), on 05/18/15 at 5:30 PM, revealed the DON stated if the LPN had entered the PRN medications into the EMAR, there would have been an automatic pop up to remind the nurse the follow-up assessment was due, regarding the effectiveness or possible side-effects of the PRN medications. However, this was not done, and there was no documented evidence the resident was assessed for effectiveness after the PRN medications were administered and the accuchecks should have been documented into the resident's record.<br><br>Interview with the Assistant Director of Nursing (ADON), on 05/18/15 at 6:00 PM, revealed she was responsible to ensure the 24 hour admission paperwork was completed correctly and she had reviewed the form, yet she did not audit the documentation but would have expected the staff to have documented correctly in the clinical record.<br><br>Interview with the Administrator, on 05/18/15 at 5:05 PM, revealed she would have expected the staff to have correctly documented in the resident's chart and on the EMARs.<br><br>** The State Survey Agency validated the corrective actions taken by the facility as follows:<br><br>1. The resident no longer resides at the facility. | F 514 | Medical Director attending at least quarterly. | 06/05/15 |

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| F 514 | Continued From page 79<br>2. Review of the 100% (81 of 81) resident assessments, dated 05/18/15, revealed the residents were assessed to determine if there were any medical needs to warrant physician notification with no concerns identified. Chart reviews were completed on Residents #4, #5 and #6 with no identified areas of concern.<br><br>3. Review of the DON and ADON conducted audits of all current residents, dated 05/18/15 to identify any resident that required a PRN medication and to ensure a follow-up assessment, monitoring for any side effect or reactions and to evaluate the effectiveness of the PRN, revealed they were completed without concerns.<br><br>4. Review of the audits dated 05/18/15 through 05/19/15 completed by the DON, ADON, Unit Managers and MDS Coordinator revealed all current residents' plans of care were reviewed to determine if all interventions were being followed and any identified interventions not in place were immediately put into place.<br><br>5. Materials and sign-in sheets, dated 05/18/15,were reviewed regarding in-services held by the Regional Quality Manager, for the Nursing Administration Staff and re-training on the EMAR system, documentation of PRN medications, physician notification, care planning and the INTERACT process were reviewed. Review of the Competency testing revealed staff had a 100% pass rate with no concerns noted. Interview with the DON, on 05/28/15 at 10:45 AM, revealed she and the Administrative Nurses had all had the re-education completed by the Regional Quality Manager related to assessments, implementing the care plan, | F 514 | | |

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| F 514 | Continued From page 80<br>change of condition, documentation of PRN medications, and physician notification and the INTERACT process.<br><br>6. Materials and sign-in sheets, dated 05/18/15-05/20/15, revealed the DON, ADON and Unit Managers re-educated all licensed staff on the same requirements with a competency test with a minimum score of 100% accuracy required. Staff interviews conducted on 05/28/15 with LPN #4 at 8:35 AM; LPN #5 at 8:51 AM; RN #2 at 10:12 AM; LPN #6 at 10:25 AM revealed the training had been completed and all the licensed staff had passed the test. On 05/18/15 through 05/20/15 all CNAs were re-educated with competency test by the DON, ADON, and the Unit Managers or MDS Coordinator, related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse and notify the nurse of a change in condition and going up the chain of command. There were competency tests with a minimum score of 100% accuracy. Staff interviews on 05/28/15 with CNA #4 at 9:17 AM; CNA #5 at 9:25 AM; CNA #6 at 10:35 AM; and CNA #7 at 10:38 AM revealed the staff verified their training had been done and they had been tested regarding the care plans and notification of a change in condition.<br><br>7. Reviews of the every shift audits, dated 05/18/15 to 05/20/15, revealed the DON, ADON, MDS Coordinator or the Unit Managers, reviewed with facility licensed nursing staff, all current residents conditions each shift, to determine if licensed staff was notifying the physician of significant changes in condition and follow up assessments were occurring based on clinical condition. Interview with the DON, on 05/28/15 at | F 514 | | |

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| F 514 | Continued From page 81<br>10:45 AM, revealed audits for residents' change of condition, notification of physician, and follow-up assessments were done on each shift until the AoC was accepted, and were now being done five times a week for twelve weeks. She stated the results of these audits will be reviewed in the QA Meetings.<br><br>8. Review of audits conducted by the DON, ADON or Unit Manager revealed five (5) residents' plans of care were reviewed to evaluate if interventions were in place and being followed.<br><br>9. Review of daily audits conducted by the DON, ADON, Unit Managers, or the MDS Coordinator revealed all narcotic records were audited daily, to identify any PRN pain medication administered and compared to EMAR records, to validate that follow up to effectiveness and adverse side effects of PRN pain medications was documented.<br><br>10. A review of the QA meetings, dated 05/20/15, 05/21/15 and 05/22/15, revealed the agenda regarded concerns with the allegation deficiencies as well as the annual survey deficiencies, complaint, and facility self-reported complaints. The meeting was attended by the Administrator, DON, Activities Director, MDS Coordinator, Business Office Manager, Dietary Services Manager, Medical Records, Housekeeping and Maintenance and the Marketing Manager. Interview with the Medical Clinical Officer (MCO) revealed the Medical Director attended the 05/18/15 meeting, by phone and was kept abreast of any concerns and the meetings were to continue weekly, then monthly until resolved. | F 514 | | |

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OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185272 | A. BUILDING _____ B. WING _____ | C 05/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MCCRACKEN NURSING AND REHABILITATION CENTER | 867 MCGUIRE AVE. PADUCAH, KY 42001 |

| (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 |
|---|---|---|---|---|
| | | | | |