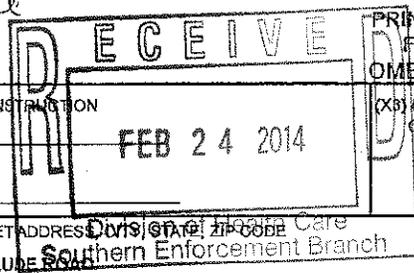


Federal

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

PRINTED: 02/06/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS 62 MAUDE ROAD INEZ, KY 41224	CITY/STATE/ZIP CODE Southern Enforcement Branch
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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
F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>A standard health survey was conducted on 01/20-23/14. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to ensure approaches for resident care were developed and addressed on a Comprehensive Plan of Care for two of fifteen sampled residents (Residents #6 and #8). Resident #6 and Resident #8 were observed to</p>	F 279	<p>Martin County Health Care Facility does not believe and does not admit that any deficiencies exist. Martin County Health Care Facility reserves the right to contest survey findings through formal dispute resolutions, formal legal appeal proceedings, or any administrative legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds. Nor is meant to establish any standard of care, contact obligation or position, and Martin County Health Care Facility reserves all rights to raise all possible contentions and defenses in any type or civil or criminal claim, action, or proceeding. Nothing contained in this plan or correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileged which Martin County Health Care Facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to our residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beth Annell, Administrator TITLE: _____ (X6) DATE: 2/14/14

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

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F 279	<p>Continued From page 1</p> <p>have pommel cushions (devices used to prevent a resident from sliding forward) in place during the survey on 01/20/14, 01/21/14, 01/22/14, and 01/23/14. However, there was no evidence the facility had developed a plan of care to address the use of the Pommel cushions for Residents #6 or #8.</p> <p>The findings include:</p> <p>A review of the Care Plans policy (dated 01/09/03) revealed a comprehensive care plan would be developed for identified problem areas and would incorporate risk factors associated with the identified problems. In addition, the policy revealed revisions would be made to the care plan as changes in the resident's condition dictated. The policy also revealed the care plan would be reviewed, at a minimum, on a quarterly basis.</p> <p>1. Review of Resident #6's medical record revealed the facility admitted the resident on 01/29/13, with diagnoses that include Anxiety and Schizophrenia.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated 12/30/13, revealed facility staff had assessed Resident #6 to have a Brief Interview for Mental Status (BIMS) score of 4 which indicated the resident's cognition was severely impaired. Continued review of the MDS revealed the facility had assessed Resident #6 to require the extensive assistance of two persons to ambulate in the resident's room and in the corridor. In addition, a review of the assessment revealed Resident #6 required the use of a trunk restraint on a daily basis due to poor safety awareness and a history of falls.</p>	F 279	<p>It is and was on the day of the survey the policy of Martin County Health Care Facility to develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>1) The Care Plans for resident #6 and #8 were updated to reflect the use of the pommel cushion.</p> <p>2) All resident care plans were reviewed by the MDS nurse to ensure that all care plans include measurable objectives and timetables to meet a residents medical, nursing, and mental/psychosocial needs that are identified in the comprehensive assessment.</p> <p>3) A conference was held on 2/10/14 with the MDS nurse given by the Director of Nursing on the necessity of putting interventions on the resident care plan correctly.</p> <p>4) As a part of the facilities ongoing CQI program the CQI Nurse will do monthly audits on 10% of the resident care plans to ensure that each residents care plan includes measurable objectives and timetables to meet a residents medical, nursing, and mental/psychosocial needs that are identified in the comprehensive assessment. Will continue audits for 6 months and cease if no problems found. Will continue audits if problems found in that time period.</p> <p>5) 2/14/14</p>	

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F 279	<p>Continued From page 2</p> <p>Observation of Resident #6 on 01/22/14, at 11:00 AM, revealed Resident #6 was sitting in a Geri-chair with a pommel cushion positioned underneath the resident's buttocks and between the inner aspects of the resident's upper thighs. A "lap buddy" (trunk restraint) was also observed to be positioned over the resident's lap area and was attached to both armrests of the resident's Geri-chair.</p> <p>However, review of the comprehensive care plan for Resident #6 dated 01/29/13, with an update of 01/02/14, revealed although an intervention had been added to the care plan to address the use of the "lap buddy," facility staff failed to address the use of the pommel cushion and failed to ensure interventions had been placed on the care plan to address the use of the pommel cushion for Resident #6.</p> <p>Review of the Nurse Assistant Care Plan for Resident #6 dated January 2014 revealed an intervention on the Nurse Assistant Care Plan for the use of a lap buddy; however, facility staff had failed to address the use of a pommel cushion for Resident #6.</p> <p>Interview conducted with State Registered Nursing Assistant (SRNA) #1 on 01/23/14, at 9:25 AM, revealed Resident #6 required a pommel cushion in the wheelchair to prevent the resident from rising and falling. According to the SRNA, nurses documented information related to each resident's needs on the Nurse Assistant Care Plan and nursing assistants were to review the care plan at the beginning of each shift. SRNA #1 stated Resident #6 had used the pommel cushion for "a long time" and acknowledged</p>	F 279		

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F 279	<p>Continued From page 3</p> <p>nurses had failed to add the use of the pommel cushion to the Nurse Assistant Care Plan. SRNA #1 stated the use of the pommel cushion should have been addressed on the Nurse Assistant Care Plan.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #1 on 01/23/14, at 9:30 AM, revealed she had been assigned to provide direct care to Resident #6 on 01/23/14. The LPN stated Resident #6 had been using a pommel cushion for a long time. The LPN stated she was responsible for adding an intervention to the care plan and the Nurse Assistant Care Plan with any changes. The LPN stated the pommel cushion should be on both the comprehensive care plan and the Nurse Assistant Care Plan and she was responsible for ensuring they match. The LPN stated she had not identified that the use of the pommel cushion was not on Resident #6's comprehensive care plan or the Nurse Assistant Care Plan and stated she "guessed" it was "just missed."</p> <p>Interview conducted with LPN #3 on 01/23/14, at 10:15 AM, revealed she was the MDS nurse who had developed the comprehensive care plan for Resident #6. The LPN stated she reviews all physician's orders daily and immediately updates the comprehensive care plan, and also updates the care plans with any new MDS assessment. The LPN acknowledged the use of the pommel cushion should have been added to Resident #6's comprehensive care plan and stated she had not been aware staff was using the pommel cushion in the wheelchair or the Geri-chair for Resident #6.</p> <p>Interview conducted with the Director of Nursing</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>(DON) on 01/23/14, at 10:30 AM, revealed she had been unaware staff had utilized a pommel cushion for Resident #6. The DON stated the nurses were responsible for reviewing the comprehensive care plan and the Nurse Assistant Care Plan to ensure the care plans matched and that all interventions were addressed. The DON stated she reviewed resident care plans on a monthly basis to ensure care plans were accurate but stated she had been unaware staff had utilized a pommel cushion for Resident #6.</p> <p>2. Observations of Resident #8 on 01/20/14 at 4:00 PM and 4:45 PM, 01/21/14 at 9:50 AM, 10:30 AM, and 11:30 AM, 01/22/14 at 10:50 AM, and 01/23/14 at 10:30 AM, revealed the resident was sitting in a wheelchair with a pommel cushion placed underneath the resident's buttocks and between the resident's inner thighs.</p> <p>Review of the medical record for Resident #8 revealed a physician's order dated January 2014 for the use of a reclining back wheelchair with pommel cushion position support.</p> <p>Review of the Comprehensive Plan of Care for Resident #8 dated 12/05/13 through 03/09/14 revealed facility staff had not addressed the use of the pommel cushion, with interventions, on Resident #8's care plan.</p> <p>Interview with Certified Nurse Aide (CNA) #2 on 01/23/14 at 12:00 PM revealed the pommel cushion was in place for Resident #8 to prevent the resident from "sliding" out of the wheelchair.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 01/23/14 at 2:25 PM revealed physician's orders are reviewed and the use of</p>	F 279		

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F 279	Continued From page 5 interventions requested by the physician are put on the plans of care. According to the MDS Coordinator, the use of the pommel cushion for Resident #8 should have been addressed on the resident's care plan. The Director of Nursing (DON) acknowledged in interview conducted on 01/23/14 at 2:50 PM that the use of the pommel cushion for Resident #8 should have been addressed on the resident's care plan.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of an incident report and the facility's policy, it was determined the facility failed to provide services in accordance with the plan of care for one of fifteen sampled residents (Resident #8). According to documentation on the written plan of care for Resident #8, facility staff was to utilize a "low bed" for the resident and to place mats at the resident's bedside due to the resident's decreased awareness of his/her safety. According to an accident/incident report, Resident #8 sustained a fall on 06/21/13, the bedside mats were not in place, and the resident sustained redness to the left wrist and a finger on the right hand.	F 282	It is and was the policy of Martin County Health Care Facility on the day of the survey to provide or arrange services by qualified persons in accordance with each resident's written plan of care. 1) The bedside mats for resident #8 were immediately put into place. 2) All residents who's rooms had orders for bedside mats to be placed on the floor were inspected to ensure that mats were in place as ordered. 3) An inservice with all nursing staff was held on 01/24/14 by the Director of Nursing on the importance of following interventions that are listed on the residents care plan.	

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F 282	<p>Continued From page 6</p> <p>The findings include:</p> <p>Review of the facility's policy for Care Plans (dated 01/09/03) revealed the care plans were developed and revised to prevent declines in the resident's function, and enhance optimal functioning.</p> <p>A review of the medical record revealed the facility admitted Resident #8 on 12/06/11 with diagnoses that included Subdural Hemorrhage (from a motor vehicle accident in 1992), Dysphagia, Contractures, and Anxiety. Review of documentation revealed on 12/06/11, facility staff developed a plan of care for Resident #8 related to the resident's impaired physical mobility, diagnosis of head trauma, and the resident's risk for falls. Continued review of the plan of care revealed on 06/29/12, staff added an intervention to the plan of care that included the use of a low bed, with mats, secondary to the resident's decreased safety awareness.</p> <p>A review of an accident and incident report revealed on 06/21/13 at 6:10 PM facility staff observed Resident #8 lying "face down" on the floor "in between the bed and the wall." Documentation on the incident report revealed Resident #8 complained of "head pain" and was observed to have an "abrasion/bruise" to the "wrist" and "finger." The incident report revealed the bedside mat was not in place at the time of the fall as indicated on the care plan.</p> <p>Observation of Resident #8 on 01/20/14 at 3:00 PM revealed the resident was on a low bed with mats at the bedside.</p> <p>Interview with CNA #2 on 01/23/14 at 2:00 PM</p>	F 282	<p>4) As part of the facilities ongoing CQI program, the CQI nurse will do monthly audits on 10% of the residents written plan of care to ensure that services are provided or arranged by qualified persons in accordance with each residents written plan of care. The audits will continue for six months and if no further issues arise the audits will cease. Will continue audits if issues found during that time period.</p> <p>5) 2/14/14</p>	

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F 282	Continued From page 7 revealed nursing staff kept each resident's plan of care up-to-date and stated staff was to provide services in accordance with the plan of care. According to CNA #2, Resident #8 would "roll" out of bed and the mats on the floor beside the resident's bed were placed there in an effort to prevent the resident from getting hurt. Interview with Registered Nurse (RN) #1 on 01/23/14 at 2:00 PM revealed facility staff utilized the mats beside Resident #8's bed in an effort to prevent injuries in the event the resident fell from the bed. Interview with the Director of Nursing (DON) on 01/23/14 at 9:10 AM revealed the CNA assigned to Resident #8 on the day of the resident's fall from bed had failed to ensure the bedside mats were in place. According to the DON, the CNA received disciplinary action related to the failure to ensure the fall mats were in place beside Resident #8's bed. The DON also stated the CNA was no longer employed by the facility.	F 282			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	It is and was on the day of the survey the policy of Martin County Health Care Facility to ensure that residents receive proper treatment and care for all special services. 1) Resident #6 oxygen was immediately set on the physician ordered setting. 2) All residents with orders for oxygen were reviewed to ensure that the resident's oxygen was set on the ordered setting.		

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F 328	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure one of fifteen sampled residents (Resident #6) received proper care and treatment related to oxygen administration. Resident #6 had a physician's order dated 12/27/13, for oxygen to be delivered at three (3) liters per nasal cannula. However, observation throughout the survey revealed Resident #6 was being administered oxygen at two (2) liters per nasal cannula. The findings include: Review of the facility's policy titled "Physician Orders," dated 08/01/13, revealed no drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses. Review of the medical record for Resident #6 revealed the facility admitted the resident on 01/29/13, with diagnoses that included Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. Review of the comprehensive care plan for Resident #6 revealed an intervention dated 02/18/13, for oxygen to be delivered as ordered. Review of the physician's orders for Resident #6 revealed a physician's order dated 12/27/13, for oxygen to be delivered at 3 liters per nasal cannula. Observations of Resident #6 on 01/20/14 at 3:50	F 328	3) The Director of Nursing conducted a nursing inservice on 01/24/13 with all licensed nursing staff on the importance of placing the residents oxygen on the ordered setting and verify this on the resident treatment record (TAR) 4) As part of the facilities ongoing CQI program, the CQI nurses will do monthly audits on 20% of residents who receive treatment and care for the following special services : injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; respiratory care; foot care; and prostheses as outlined in the resident plan of care. The audits will continue for 6 months and if no further issues arise the audits will cease. Will continue audits if issues found during that time period. 5) 2/14/14	

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F 328	Continued From page 9 PM, 5:00 PM, and 5:15 PM, and on 01/21/14 at 10:20 AM, 11:30 AM, and 12:15 PM, all revealed the resident was being administered oxygen at 2 liters per nasal cannula. Interview conducted with Licensed Practical Nurse (LPN) #1 on 01/23/14, at 9:30 AM, revealed she had been responsible for the care of Resident #6 on 01/20/14 and 01/21/14. The LPN stated she was required to check the oxygen settings when she made her morning rounds and stated she had failed to check Resident #6's oxygen settings on 01/20/14 and 01/21/14 as required. Interview conducted with the Director of Nursing (DON) on 01/23/14 at 10:30 AM, revealed she made rounds every morning to observe the residents and ensure staff provided the care and treatment as planned. However, the DON stated she had not monitored oxygen settings while making her rounds. The DON stated the nurse was required to check the oxygen settings and ensure the oxygen was being administered at the proper setting.	F 328			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: The facility failed to ensure a therapeutic diet prescribed by the physician was served to one of fifteen sampled residents (Resident #6). Resident #6 was served a pureed food tray during	F 367	It is and was the policy of Martin County Health Care Facility on the day of the survey to provide diets as prescribed by a physician. 1) Resident #6 diet was immediately changed to the physician ordered diet. 2) All resident diet orders were reviewed by the Dietary Manager to ensure that they were given as physician ordered.		

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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	
F 367	<p>Continued From page 10</p> <p>the evening meal on 01/20/14 and the noon meal on 01/21/14; however, a review of the physician's orders for Resident #6 dated 12/27/13, revealed the resident was to receive a mechanical soft diet with chopped meats.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Physician's Orders," dated 2013, revealed it was the policy of the facility to have written physician's orders for all therapeutic diets and texture modifications served to the residents.</p> <p>A review of Resident #6's medical record revealed physician's orders, dated 12/27/13, for a mechanical soft diet with chopped meats.</p> <p>Observation of the evening meal on 01/20/14 and the noon meal on 01/21/14 revealed Resident #6 was served a pureed food tray.</p> <p>Interview conducted with Registered Nurse (RN) #1 on 01/22/14, at 10:30 AM, revealed she was responsible for monitoring all physician's orders to ensure each physician's order was carried over to the next month's orders. According to the RN, on 11/23/13 Resident #6's physician prescribed a pureed diet with thin liquids; however, RN #1 stated the order written on 11/23/13 had not been carried over to the physician's orders dated 12/27/13. RN #1 stated although the diet order written on 11/23/13 had not been carried over to the orders dated 12/27/13, Resident #6 had received the appropriate therapeutic diet. The RN stated she had just overlooked the diet order.</p> <p>Interview conducted with the Director of Nursing (DON) on 01/23/14, at 10:30 AM, revealed she</p>	F 367	<p>3) A nursing inservice was held with all nursing staff on 01/24/2014 by the Director of Nursing to ensure that staff checks the accuracy of diets as compare to the physician order and plan of care.</p> <p>4) As a part of the facilities on going CQI program the CQI nurse will conduct a weekly audit on 10 meals a week to ensure that the meals reflect the physician order and care plans. The audits will continue for 6 months and if no further issues arise the audits will cease. Will continue audits if issues found during that time period.</p> <p>5) 2/14/14</p>		

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

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F 367	Continued From page 11 also reviewed the physician's orders at the end of every month. The DON stated she had overlooked the physician's diet order written on 11/23/13 for Resident #3 and had failed to ensure the order was carried over to the next month's orders.	F 367			