

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 05/18/14 and concluded on 05/21/14 with deficiencies cited at the highest scope and severity of a "D".

This was a Nursing Home Initiative survey with entrance to the facility on Sunday May 18, 2014 at 2:00 PM.

F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF SS=C RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.

F 000

F 156 F 156

1. The facility is displaying written information on how to apply for and use Medicare and Medicaid benefits which are accessible to all four units. This was posted on 5/20/14.
- The facility is providing Liability Notices to residents per Medicare guidelines.
2. The facility is displaying written information on how to apply for and use Medicare and Medicaid benefits which are accessible to all four units.
- The facility is providing Liability Notices to residents per Medicare guidelines. All residents currently utilizing Medicare benefits are current in any Liability Notices that she be provided per Medicare guidelines. The Business Office Manager completed an audit for

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X <i>[Signature]</i>	TITLE X NHA	(X6) DATE X 7/07/14
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's current policies and procedures 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 156 Continued From page 1

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

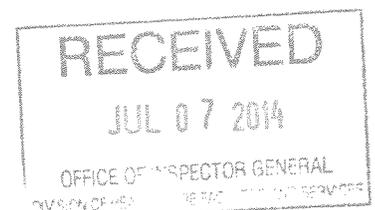
A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

F 156

Medicare residents who resided in the facility for the 60 days prior to May 21, to identify any residents who may have been affected. This audit was completed on 7/03/14. Any identified residents were notified by 7/04/14.

3. The facility is reviewing all residents utilizing Medicare benefits weekly in a Medicare meeting which is attended by the Administrator, Assistant Directors of Nursing, Business Office Manager, MDS Coordinator, and Rehab Services Manager. Any potential discharges from the facility, benefits exhausting, or residents who no longer meet skilled nursing criteria are discussed and it is determined at this point who the facility needs to provide a Liability Notice to and for what date. The facility is reviewing planned discharges five times a week in the morning department head meeting. Any potential discharges from the facility, benefits exhausting, or residents who no longer meet skilled nursing criteria are discussed and it is determined at this point who the facility needs to provide a Liability Notice to and for what date.



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F 156 Continued From page 2

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, it was determined the facility failed to prominently display in the facility written information on how to apply for and use medicare and medicaid benefits for four (4) of four (4) units, in addition the facility failed to provide the appropriate liability and appeal notices for one (1) of three (3) sampled medicare recipients, Resident #23.

The findings include:

The facility did not provide a policy regarding the posting of required resident information specifically how to apply for Medicare/Medicaid.

Observations during the Environment Tour, on 05/20/14 at 2:03 PM, revealed there was no Medicare/Medicaid posting through out the building.

Interview with the Administrator, on 05/20/14 at 2:03 PM, revealed she did not know where the posting had went. The Administrator stated she

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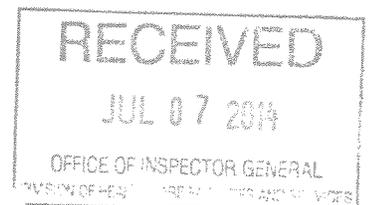
The Regional Business Office Consultant reeducated the Administrator, Business Office Manager, and Assistant Business Office Manager on 5/27/14 on the Medicare guidelines for Liability Notices and also on required information that needs to be displayed for residents and their families to refer to.

4. The Business Office Manager will conduct an audit monthly times six months to ensure proper postings of Medicare and Medicaid information in locations accessible to all residents.

The Administrator will conduct an audit weekly times eight weeks then monthly times four months of discharged residents and residents whose Medicare benefits are no longer being utilized to ensure Liability Notices have been provided per Medicare guidelines.

The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

Completion Date: July 4, 2014



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thought the poster was hanging next to the Patient Rights Poster and was not aware the Medicare/Medicaid sign was not posted.

2. Interview with the Administrator, on 05/21/14 at 3:04 PM, revealed the facility did not have a policy specific to Liability Notices and stated they followed the federal regulation.

Review of Resident #23's closed record revealed a Liability Notice was not provided to the resident.

Interview with the Bookkeeper, on 05/20/14 at 1:30 PM, revealed Resident #23 was not given a liability notice because he/she abruptly left. Resident #23 decided he/she did not want to be in the facility.

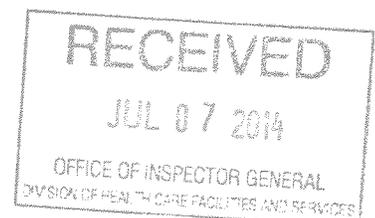
Review of Resident #23's Physician Progress Notes, dated 04/30/14, revealed the Physician documented that Resident #23 would be discharged home in the morning.

Review of Resident #23's Discharge Instructions for Care dated 05/01/14, revealed Resident #23 was to have Home Health Services and was to receive therapy.

Interview with the Director of Nursing (DON), on 05/20/14 at 3:23 PM, revealed Resident #23 was discharged with a plan and was not abruptly discharged.

Interview with the Bookkeeper, on 05/20/14 at 1:30 PM, revealed residents were given the liability notice because they have the right to appeal. The Bookkeeper stated if residents were not given the liability notice then their right to

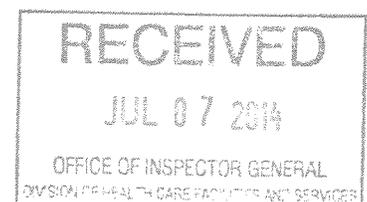
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F 156	Continued From page 4 appeal would be taken away. Interview with the Administrator, on 05/21/14 at 3:04 PM, revealed she thought residents were supposed to receive liability notices only if their services was running out and was not aware every resident was to receive a notice upon discharge.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure survey results were available for examination in a place readily accessible to residents with posted notices of their availability for four (4) of four (4) units. In addition, abbreviated surveys on 05/06/13, 07/09/13 and 10/01/13 were not made available in the survey binder. The findings include: 1. Observation of the Front Lobby, on 05/20/14 at	F 167 F 167	<ol style="list-style-type: none"> 1. Survey results were made available on 5/20/14 for examination by each nurses station to residents with posted notices available to all four units. Signs are located by the dining room on each floor indicating the locations of the binders. All annual and abbreviated surveys completed in 2013 and 2014 are in each survey binder. 2. Survey results are available for examination in a place readily accessible to residents with posted notices available to all four units. Signs were posted on 5/20/14 and are located by the dining room on each floor indicating the locations of the binders. All annual and abbreviated surveys completed in 2013 and 2014 are in each survey binder. 	



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F 167 Continued From page 5
8:12 AM, revealed the survey book was behind locked doors in which residents with Wander Guard devices could not access because of egress.

Observation of the Front Lobby, on 05/20/14 at 2:00 PM, revealed no sign posting the availability of the survey results within ten (10) feet of the reception desk.

Review of the Wander Guard list, revealed there were twenty-six (26) residents out of a census of one hundred and twenty-nine (129) residents who did not have access to the Front Lobby.

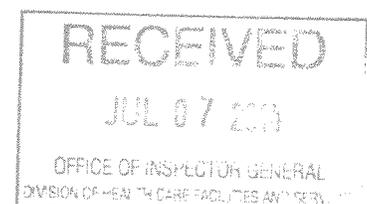
Interview with the Administrative Assistant, on 05/20/14 at 2:03 PM, revealed she had not seen a sign about the survey results being available for viewing.

2. Review of the survey binder, on 05/20/14 at 2:00 PM, revealed abbreviated surveys that were conducted on 05/16/13, 07/09/13 and 10/01/13 were not made available for resident viewing.

Interview with the Administrator, on 05/20/14 at 2:03 PM, revealed she was aware that the survey results were to be made available. The Administrator agreed that residents with Wander Guard devices would not have access off the unit and could not review the survey binder. The Administrator stated she thought if the resident requested to see the survey results, she would go and obtain the survey binder for them. The Administrator stated she was not aware the abbreviated surveys were not in the survey binder. She stated she was here for the complaint on 05/16/13 and the findings should be in the binder; however, regarding the abbreviated

F 167

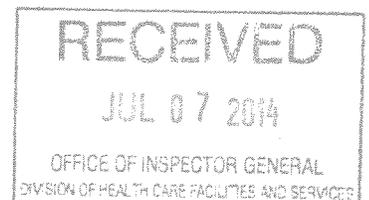
3. The Administrator, Staff Development Coordinator, Environmental Services Director, Dietary Manager, and Director of Nursing have reeducated all staff on 6/27/14 to the location of the survey binders. The Quality of Life Director and Quality of Life Assistants have reeducated residents by 6/20/14 to the locations of the survey binder.
4. The Administrator and Director of Nursing will audit the survey binders monthly times six months to ensure all annual and abbreviated survey results are available and the binder is accessible to all residents on all four units. The results of this audit will be forwarded to the Quality Assurance Committee for further review and recommendations.
5. Completion Date: June 27, 2014



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F 167	Continued From page 6 surveys on 07/09/13 and 10/01/13, she was on medical leave and there was an acting Administrator. The Administrator stated all surveys should be in the survey binder.	F 167			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272 F 272	<ol style="list-style-type: none"> The Social Services Assistant has conducted an assessment on residents #7 on 6/02/14 and #13 on 5/29/14 that included cognition, mood, and behavior patterns. An audit was completed by the Administrator and MDS Coordinator on 6/20/14 on all residents admitted or readmitted in the last 45 days to ensure assessment were completed including cognition, mood, and behavior patterns. The Administrator and MDS Coordinator have reeducated the Social Services Assistant on 5/22/14 on completing comprehensive assessments timely. The new Social Services Director who will begin working on June 30 will be educated during orientation on completing timely assessments for all residents. 		



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This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the Resident Assessment Instrument (RAI) Manual, it was determined the facility failed to conduct an initial comprehensive assessment that included cognition, mood, and behavior patterns for two (2) of twenty-four (24) sampled residents. Residents #7 and #13.

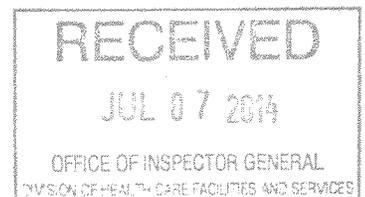
The findings include:

The facility did not provide a specific policy for completion of the RAI process, but referred to the RAI Manual. Review of the RAI 3.0 Manual the facility was utilizing revealed updates on October 2011, May 2011, and April 2012 for the sections of cognition patterns, mood, and behaviors. On page C-1 the manual stated the intent of the cognitive patterns assessment was to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care planning decisions. The manual stated most residents were able to attempt the Brief Interview for Mental Status (BIMS). If the resident chose not to participate or had given a nonsensical response then the staff assessment of mental status should be completed (page C-17). If the test cannot be conducted (resident would not cooperate, was non-responsive, etc) and staff were unable to make a determination based on observation of

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4. The Administrator will audit assessments for cognition, mood and behavior patterns weekly times eight weeks per the MDS schedule, then monthly times four months. The results of these audits will be forwarded to the Quality Assurance Meeting for further review and recommendations.

Completion Date: June 20, 2014



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F 272 Continued From page 8
the resident, then the staff was to use the standard "no information" code (dash"-") to indicate that the information was not available because it could not be assessed. (Page C-21)

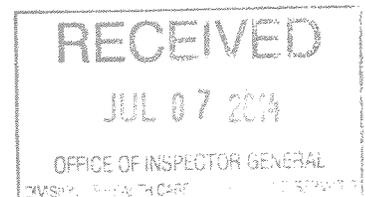
Continued review of the RAI 3.0 Manual revealed the same instructions for the resident mood interview. The resident mood interview was preferred as it improved the detection of a possible mood disorder. However, a small percentage of patients are unable or unwilling to complete the interview. Therefore, staff should complete the staff assessment of mood that would include staff observations. (Page D-11, 12) This ensured that information about their mood was not overlooked. Recognition and treatment of depression in the nursing home could be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community.

1. Review of Resident #13's clinical record revealed the facility admitted the resident on 05/06/14 for a short term rehab stay. Review of the nursing admission assessment for that day revealed the facility assessed the resident to be alert and oriented.

Observation of Resident #13, on 05/19/14 at 3:05 PM, revealed the resident in the therapy room utilizing a hand bicycle machine. The resident was observed to follow the therapist's instructions promptly and correctly.

On 05/20/14 at 9:10 AM, a Quality of Life Assessment interview was conducted by the surveyor and found the resident could answer all the questions.

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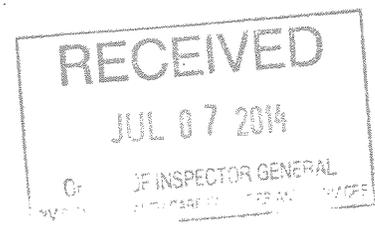
F 272 Continued From page 9

Review of the admission RAI, completion date of 5/19/14, revealed the facility failed to assess the resident's cognitive patterns, Delirium, and Mood with dashes entered instead of codes. The facility did not conduct the resident interview or the staff interview for these sections.

2. Review of Resident #7's clinical record revealed the facility admitted the resident on 05/05/14. Review of the admission MDS assessment, completed on 05/15/14, revealed dashes were entered instead of a code for the section of hearing, speech, vision, cognitive patterns, delirium, mood and behaviors. Neither the resident interview or staff interview were conducted.

Interview with the Minimum Data Set (MDS) Coordinator, on 05/21/14 at 3:32 PM, revealed she was not usually responsible for those sections, the Social Service department would complete them. She stated when she reviewed the above admission assessment she discovered the cognition and mood sections had not been completed for Resident #13 and Resident #7. She indicated the Social Service staff would conduct the BIMS interview and the PHQ-9 test. They were supposed to be completed prior to the Assessment Reference Date (ARD) which was 05/13/14 for Resident #13 and 05/12/14 for Resident #7. She stated since those test results were not available, she had entered dashes(-) because she did not know the answers. She revealed the Social Service staff responsible for those sections left abruptly last Monday, 05/12/14 without notice and when she went to look for the completed tests, She could not find them. She said she had put dashes because she did not have that information and could not conduct the

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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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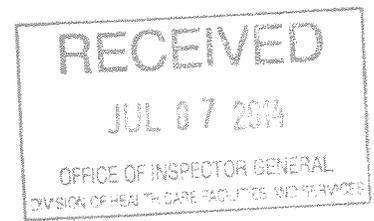
F 272 Continued From page 10

interview after the ARD date. She stated the Corporate Consultant had trained her to put dashes if she did not know the answers and had told her it had to be completed the day of or before the ARD date. She stated she followed the RAI 3.0 manual. She further stated she didn't fill out the staff interview section, because she didn't know she could. The surveyor and MDS Coordinator reviewed the RAI manual together and found dashes are not for when the staff failed to conduct the test, it was for when the resident could not answer the questions and the staff did not know or could not obtain the answers. She stated she did not know she could have conducted the staff interview section.

Interview with the Administrator, on 05/21/14 at 4:59 PM, revealed one of two Social Workers had left on 5/12/14. She stated she assigned the other Social Worker to complete MDS assessments that would include the BIMS test. However, she indicated she had not given specific instructions to that Social Worker. She was unaware the Social Worker had not completed the required assessment before they left. She stated she had not followed up to see if all paperwork had been completed when the other Social Worker left.

Interview with the remaining Social Worker, on 05/21/14 at 5:10 PM, revealed it was her second day at the nursing facility when the other Social Worker left. She was still in training mode. She stated she immediately found lots of problems and found a list of residents names that were marked as completed for the MDS sections. However, she could not find the completed BIMS interviews for Residents #7 and #13. She stated she had informed the Administrator and the MDS Coordinator, however, the MDS Coordinator had

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F 272 Continued From page 11
already set the ARD date and she would not make up the information. She stated she did not know she could complete the staff interview. She just didn't want to do anything dishonest. However, the other Social Worker left on 05/12/14 and the ARD date for Resident #13's assessment was for 05/13/14.

F 272

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

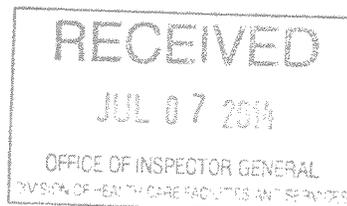
F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, it was determined the facility failed to revise the comprehensive care plan for one (1) of twenty-four (24) sampled residents, Resident

1. The Director of Nursing has updated the care plan for resident # 19 on 5/30/14 to address identified issues from her recent hospital admissions.
2. The Director of Nursing and Assistant Directors of Nursing completed an audit of readmissions from the hospital in the last 60 days on 6/20/14 to ensure their care plans have been updated appropriately.
3. On the Director of Nursing reeducated on 6/20/14, the Assistant Directors of Nursing, MDS Coordinator, and Unit Managers on updating care plans when a resident is readmitted from the hospital or has a change in condition. The Staff Development Coordinator reeducated the licensed nursing staff on 6/27/14 on updating care plans as



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F 280 Continued From page 12
#19, after the resident experienced two (2) episodes of gastric bleeding requiring hospitalization and blood transfusions.

The findings include:

Interview with the Director of Nursing, on 05/21/14 at 11:00 AM, revealed the facility had no policy on revising care plans; however, she stated care plans were revised quarterly and when there was a change in the resident's condition.

Observation of Resident #19, on 05/20/14 at 9:00 AM, revealed the resident was up in a wheelchair in the room. A sensor pad was in place on the wheelchair. The resident was alert; however, thinking was disorganized and responses to questions were not appropriate.

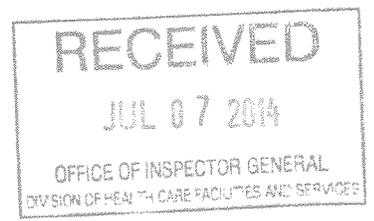
Review of the clinical record for Resident #19, revealed the resident was sent to the hospital on 10/10/13 with Pneumonia and evidence of a Gastrointestinal Bleed. At the hospital, the resident tested positive for blood in the stool. In addition, the resident's hemoglobin had dropped to 7-8. The resident's hemoglobin was within normal limits, at 13, in May 2013. The source of the bleeding was not pinpointed. Blood transfusions were administered to restore the resident's hemoglobin levels.

Further review of the clinical record, revealed the resident was sent to the hospital on 03/06/14 with a Urinary Tract Infection. The discharge summary from the hospital, dated 03/10/14, indicated the resident had a profound anemia on admission. The resident's hemoglobin had dropped to 6. There was evidence of tarry stools; however, the source of the bleeding was not

F 280 residents are readmitted from the hospital or have a change in condition.

4. The Director of Nursing will audit the care plans of all residents readmitted from the hospital for eight weeks to ensure care plans were updated appropriately. The Director of Nursing will continue to audit monthly a sample of five residents who were readmitted from the hospital, unless this exceeds the number of readmissions for that month. This audit will be ongoing. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

Completion Date: June 27, 2014



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F 280 Continued From page 13
located. Again, blood transfusions were used in the hospital to restore the resident's hemoglobin level.

Review of the Comprehensive Care Plan for Resident #19, revealed the absence of a care plan with interventions to detect gastrointestinal bleeding or to monitor for bleeding from other sites.

Interview with Licensed Practical Nurse (LPN) #2, on 05/20/14 at 2:10 PM, revealed the care plan did not contain the problem of bleeding or interventions to detect bleeding sooner to prevent the hemoglobin from falling to low levels dangerous to the resident. She stated the care plan should have been revised, after the first episode of bleeding, to include interventions to detect bleeding. She stated the revisions should have been made by the nurses caring for the resident or the nurse completing the Minimum Data Set (MDS) assessments. She indicated a low hemoglobin was a serious concern for the resident's well-being.

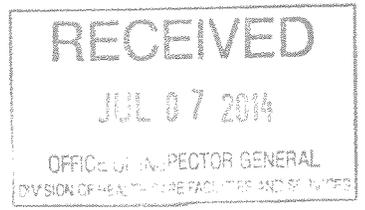
Interview with the MDS Nurse, on 05/20/14 at 2:45 PM, revealed the care plan should have been revised to include interventions to detect gastrointestinal bleeding. She stated bleeding was a serious concern for the resident and required acute hospital care. She stated the unit nurses, unit managers and she were responsible for revising care plans to address resident problems. She could not explain how the hospitalizations for bleeding were missed.

F 280

F 281

1. Licensed nursing staff are applying and

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS



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F 281 Continued From page 14
The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the Medication and Treatment Orders Policy, it was determined the facility failed to follow physician (MD) orders to remove a Lidocaine patch for one (1) of twenty-four (24) sampled residents and two (2) unsampled residents, Unsampled Resident A. During the morning medication (med) pass, LPN #1 removed a Lidocaine patch from Unsampled Resident A when a new patch was placed. The resident's physician had ordered the patch be removed at bedtime.

The findings include:

Review of the facility's policy regarding Medication and Treatment Orders, revised January 2014, revealed medications would be administered upon the written order of a person licensed and authorized to prescribe the medications in this state.

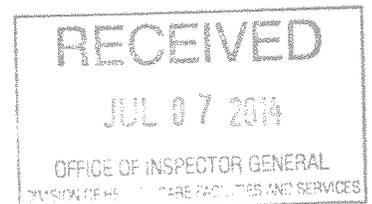
Review of the Lidocaine patch packet revealed the patch should be applied only up to twelve (12) hours in a twenty-four (24) hour period. The patch should be applied for twelve (12) hours and removed after twelve (12) hours.

Review of the clinical record for Unsampled Resident A revealed the facility admitted the resident on 02/24/14 with diagnoses of Paralysis Agitans and Senile Dementia. The facility's Physician Order Sheet (POS) for May 2014

F 281:

- removing the Lidocaine patch on resident A per physician orders.
- The Assistant Director of Nursing and the Unit Managers completed an audit on 6/20/14 to identify other residents who have an order for a Lidocaine patch. The licensed nursing staff are applying and removing the Lidocaine patches per physician orders.
 - The Staff Development Coordinator has reeducated all licensed nursing staff on 6/27/14 on following physician orders including orders for the application and removal of Lidocaine patches.
 - The Assistant Director of Nursing and Unit Managers will complete weekly audits for eight weeks then monthly audits times six months on those residents with lidocaine patches to ensure they are being applied and removed per physician orders. These audits will not be ongoing unless an issue is identified during the audits. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

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F 281 Continued From page 15

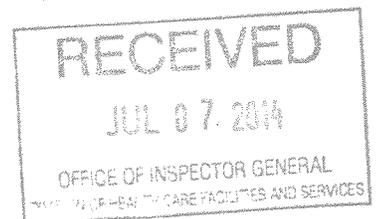
revealed a Lidoderm patch was ordered to be placed on the resident at 8:00 AM and removed at 8:00 PM every day. The Medication Administration Record (MAR) for May 2014 revealed the Lidoderm patch was signed as removed at 8:00 PM on 05/18/14. A nurse's note, on 05/19/14 at 9:40 AM, revealed a Lidoderm patch was removed from Resident A.

Observation, on 05/19/14 at 8:47 AM, of med pass revealed Licensed Practical Nurse (LPN) #1 placed a Lidocaine patch on Resident A's back and removed an old patch.

Interview with LPN #1, on 05/21/14 at 2:31 PM, revealed the Lidocaine patch should be removed from Resident A at 8:00 PM per the MD order. She stated she had been trained to follow MD orders in orientation at the facility. The nurse indicated she was unsure of what effects would occur to the resident with the patch left on twenty-four (24) hours. The LPN further indicated the nurse on duty should sign the MAR when the patch was removed. She stated she was unaware if anyone at the facility monitored administration or removal of patches.

On 05/21/14 at 3:00 PM, interview with the Director of Nursing (DON) revealed the nurse who passed the 8:00 PM meds was responsible to remove Resident A's Lidocaine patch. The DON indicated she was unsure what the effects to Resident A would be if the patch was left on twenty-four (24) hours. She stated the nurses document on the MAR when the patch was placed on the resident, and when the patch was removed. The DON further indicated she had been at the facility two (2) months and would monitor nurses during med pass every six (6)

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F 281	<p>Continued From page 16</p> <p>months. She stated she had not yet monitored a med pass. She further stated the Assistant Director of Nursing (ADON) was responsible to monitor med pass. The DON indicated she was unaware what could happen to Resident A if the MD order to remove the Lidocaine patch at 8:00 PM was not followed by the nurse.</p> <p>Interview, on 05/21/14 at 3:23 PM, with the ADON revealed she did not usually monitor med pass; however, would occasionally monitor for the Quality Assurance (QA) meeting held quarterly. The ADON stated she could not remember the last time she monitored med pass. She indicated at the time the Lidocaine patch should be removed, the nurse on duty was responsible to remove the patch. She further indicated all nurses were trained how to apply and remove a patch during orientation. The ADON stated when the nurse signed for the removal of the patch at 8:00 PM on the MAR, the nurse had indicated the patch had been removed. She stated the MD had ordered the Lidocaine patch for Resident A to be on for twelve (12) hours. The ADON indicated she was unsure what could happen to Resident A if the patch was not removed.</p>	F 281		

