

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

PRINTED: 09/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 09/11/2015
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NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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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}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 08/24/15, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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	INITIAL COMMENTS AMENDED An Abbreviated Survey investigating Complaint KY #23549 was conducted on 07/31/15 through 08/04/15. Complaint KY #23549 was unsubstantiated with unrelated deficiencies cited at the highest S/S of a "D".	F 000	For the resident affected: On 8/3/15 Resident # 2's oxygen was reapplied as ordered. A respiratory assessment was completed by a licensed nurse and the physician notified of the assessment findings. Oxygen is currently being administered per physician orders. The care plan has been reviewed by the interdisciplinary team (IDT) and was noted as current and compliant per physician orders related to oxygen administration. The IDT is composed of a Registered Nurse, Activities Director, Social Services Director, and a Dietary Manager. For other residents possibly impacted: On 8/3/15, all residents with physician orders for oxygen were assessed for oxygen administration delivery according to physician's orders and all were compliant. Additionally the residents' care plans were reviewed by the IDT per physician orders related to oxygen administration and all were compliant. Systemic Changes: By 8/12/15, respiratory policies and procedures were reviewed and updated to clarify oxygen administration is to be performed by licensed nursing personnel. By 8/12/15 all licensed nursing staff were educated by the RN Staff Development Coordinator (SDC) on oxygen administration, following physician orders related to oxygen, and monitoring the resident receiving oxygen. By 8/12/15, all unlicensed direct care staff were educated by the RN SDC on the revised respiratory policies and procedures specifically that only licensed nurses are to administer oxygen. During the orientation process, all licensed nurses and unlicensed direct care staff will be educated on the respiratory policies and procedures. Licensed nurses will be required to demonstrate competency in oxygen delivery per physicians' orders, perform a thorough respiratory assessment, demonstrate required documentation of the assessment, and demonstrate acceptable critical	8/24/15
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, interview, record review and facility policy review, it was determined the facility failed to implement the care plan for one (1) of three (3) sampled residents (Resident #2). Resident #2 was care planned for Oxygen per physician's orders; however, observation revealed Resident #2's oxygen concentrator was not turned on. The resident's O2 saturation was 75% (normal 95-100%). The findings include: Review of facility policy titled, "Comprehensive Care Plan", not dated, revealed it was the policy of the facility to 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	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robin Chappell</i>	TITLE Administrator	(X6) DATE 9/11/15
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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 282	<p>Continued From page 1 assessment.</p> <p>Record review revealed the facility admitted Resident #2 on 06/05/15 with diagnoses which included Congestive Heart Failure, Asthma, and Unspecified Acute Edema of Lung. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 06/05/15, revealed the facility assessed Resident #2's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen "15" and he/she required total assistance with activities of daily living (ADLs).</p> <p>Review of Resident #2's Comprehensive Care Plan for Oxygen (O2) Therapy with a target date of 09/14/15, and review of the July 2015 Physician's Orders, revealed an to administer oxygen (O2) at three (3) liters per minute (lpm) per nasal cannula (N/C).</p> <p>Observation on 08/03/15 at 12:50 PM revealed Resident #2 with a N/C in his/her nose but the O2 concentrator was not turned on.</p> <p>Interview with Resident #2, on 08/03/15 at 1:05 PM, revealed he/she had been in the room over an hour.</p> <p>Observation on 08/03/15 at 1:04 PM with Licensed Practical Nurse (LPN) #1 revealed her placing pulse oximeter on Resident #2 fingers with Oxygen level rising to 75%.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 08/03/15 at 1:12 PM, revealed she had forgotten to turn on the oxygen concentrator when she had taken Resident #2 back to the room and she needed to make sure it was working before she left the room.</p>	F 282	<p>thinking processes relate to physician and family notification. Monitoring: On 8/3/15 and ongoing thereafter, licensed nurses will monitor all their assigned residents with orders for oxygen every shift. Physicians' orders will be reviewed daily by the DON or RN designee for new or changing physicians' orders related to oxygen. Daily audits of current order and any order changes will be performed by the DON or RN designee to ensure the orders are accurately reflected on the Medication Administration Record (MAR) and the care plan as well as assess the resident for oxygen administration delivered according to the change. The DON will bring the result of the audits to the Performance Improvement Team Monthly x 3 months for any revision or plan recommendations based on audit results. The Performance Improvement Team consists of the Administrator, Director of Nursing, MDS Coordinator, Environmental Services, Social Services Director, Activities Director, Dietary Manager, and a Licensed Therapy representative.</p>	
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F 282	Continued From page 2 Interview with the Assistant Director of Nursing, on 08/03/15 at 2:18 PM, revealed the nurse should make sure the oxygen is turned on and it is ultimately the nurses responsibility. She stated the CNA should not leave the room without making sure the resident was receiving oxygen. Interview on 08/03/15 at 1:50 PM with Director of Nursing (DON) revealed Oxygen should be turned on for Resident #2.	F 282	For the resident affected: On 8/3/15 Resident # 2's oxygen was reapplied as ordered. A respiratory assessment was completed by a licensed nurse and the physician notified of the assessment findings. Oxygen is currently being administered per physician orders. The care plan has been reviewed by the interdisciplinary team (IDT) and was noted as current and compliant per physician orders related to oxygen administration. The IDT is composed of a Registered Nurse, Activities Director, Social Services Director, and a Dietary Manager. For other residents possibly impacted: On 8/3/15, all residents with physician orders for oxygen were assessed for oxygen administration delivery according to physician's orders and all were compliant. Additionally the residents' care plans were reviewed by the IDT per physician orders related to oxygen administration and all were compliant. Systemic Changes: By 8/12/15, respiratory policies and procedures were reviewed and updated to clarify oxygen administration is to be performed by licensed nursing personnel. By 8/12/15 all licensed nursing staff were educated by the RN Staff Development Coordinator (SDC) on oxygen administration, following physician orders related to oxygen, and monitoring the resident receiving oxygen. By 8/12/15, all unlicensed direct care staff were educated by the RN SDC on the revised respiratory policies and procedures specifically that only licensed nurses are to administer oxygen. During the orientation process, all licensed nurses and unlicensed direct care staff will be educated on the respiratory policies and procedures. Licensed nurses will be required to demonstrate competency in oxygen delivery per physicians' orders, perform a thorough respiratory assessment, demonstrate required documentation of the assessment, and demonstrate acceptable critical	8/24/15	
F 328	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. 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 (1) of three (3) sampled residents (Resident #2) received the proper treatment and care related to respiratory care. Observation revealed Resident #2's oxygen cannula was in place; however, the oxygen concentrator was not turned on. The resident's oxygen saturation was 75%.	F 328			

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F 328	Continued From page 3 The findings include: Review of facility policy titled, "Respiratory Care Services Policy & Procedure: Oxygen Concentrator Management, last revised July 2000, revealed a concentrator was the oxygen source used to relieve hypoxia, decrease the work of breathing, and decrease myocardial work. The procedure for use of an oxygen concentrator was to obtain physician order, plug concentrator into electrical source and turn concentrator on. Place nasal cannula in resident's nose. Record review revealed the facility admitted Resident #2 on 06/05/15 with diagnoses which included Congestive Heart Failure, Asthma, and Unspecified Acute Edema of Lung. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 06/05/15, revealed the facility assessed Resident #2's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen "15" and he/she required total assistance with activities of daily living (ADLs). Review of Resident #2's Comprehensive Care Plan for Oxygen (O2) Therapy with a target date of 09/14/15, revealed an intervention for O2 per nasal cannula (N/C). Review of Resident #2's July 2015 Physician Orders and Treatment Administration Record revealed an order for oxygen (O2) at three (3) liters per minute (lpm) per nasal cannula (N/C). Observation on 08/03/15 at 12:50 PM revealed Resident #2 with a N/C in his/her nose but the O2 concentrator was not turned on.	F 328	thinking processes relate to physician and family notification. Monitoring: On 8/3/15 and ongoing thereafter, licensed nurses will monitor all their assigned residents with orders for oxygen every shift. Physicians' orders will be reviewed daily by the DON or RN designee for new or changing physicians' orders related to oxygen. Daily audits of current order and any order changes will be performed by the DON or RN designee to ensure the orders are accurately reflected on the Medication Administration Record (MAR) and the care plan as well as assess the resident for oxygen administration delivered according to the change. The DON will bring the result of the audits to the Performance Improvement Team Monthly x 3 months for any revision or plan recommendations based on audit results. The Performance Improvement Team consists of the Administrator, Director of Nursing, MDS Coordinator, Environmental Services, Social Services Director, Activities Director, Dietary Manager, and a Licensed Therapy representative.	

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F 328	Continued From page 4 Interview with Resident #2, on 08/03/15 at 1:05 PM, revealed he/she had been in the room over an hour. Interview and observation, on 08/03/15 at 2:00 PM, with Licensed Practical Nurse (LPN) #1 revealed the LPN was turning the oxygen concentrator on and placing a pulse oximeter on the finger of Resident #1. The pulse oximeter reading was 75%, and the LPN stated Resident #2 was supposed to have continuous oxygen and the concentrator was not turned on because staff had not turned it on after bringing the resident back to his/her room. LPN #1 administered a duoneb treatment to Resident #2. LPN #1 further stated the lack of oxygen could be potentially fatal , and the resident could have shortness of breath, and any kind of respiratory issue could happen. Interview with Certified Nurse Aide (CNA) #3, on 08/03/15 at 1:12 PM, revealed she had forgotten to turn on the oxygen concentrator when she had taken Resident #2 back to the room and she needed to make sure it was working before she left the room. Interview with the Assistant Director of Nursing, on 08/03/15 at 2:18 PM, revealed the nurse should make sure the oxygen is turned on and it is ultimately the nurses responsibility. She stated the CNA should not leave the room without making sure the resident was receiving oxygen. Interview on 08/03/15 at 1:50 PM with Director of Nursing (DON) revealed Oxygen should be turned on for Resident #2.	F 328			