

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/23/2014
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 282	<p>Continued From page 38</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the Minimum Data Set (MDS) assessment, nursing and Interdisciplinary Team Notes, physician's orders, Comprehensive Care Plan, hospital's Emergency Department Physician Chart, and Death Certificate it was determined the facility failed to provide care in accordance with the plan of care of one (1) of five (5) sampled residents (Resident #5). Registered Nurse (RN) #1 failed to monitor vital signs, monitor for signs and symptoms of dehydration, monitor for change in level of consciousness, monitor for shortness of breath, monitor for cyanosis, administer oxygen (O2) as needed, provide Meds/treatments as ordered, report adventitious breath sounds, and update the physician as needed per Resident #1's plan of care.</p> <p>On 11/29/13 when RN #1 came on duty at 7:00 PM she was made aware Resident #1 was a little lethargic and she needed to obtain urine for an Urinalysis because the physician thought the resident might have a Urinary Tract Infection (UTI). ON 11/30/13 at 5:00 AM, the Certified Nurse Aide (CNA) reported to RN #1 that Resident #1 was not drinking, having diarrhea and hard to arouse. RN #1 looked in on the resident and obtained the resident's vital signs then called and left a message for the physician sometime between 5:30 AM-6:00 AM. At 6:00 AM, the physician called the facility and RN #1 received orders for a Complete Blood Count (CBC), Comprehensive Metabolic Profile (RCMP), Urinalysis (UA), chest x-ray, intravenous fluids (IV), Normal Saline at 90 cubic centimeters (cc) per hour (hr), and IV Flagyl (an antibiotic)</p>	F 282	<p>gastro-intestinal using the interact guidelines and pathways as a guide, not to supersede the judgment of the nurses in attendance. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this re-education. On 12/14/2013 the Regional Nurse Consultant provided education to the Director of Nursing and the Unit Manager for hall one related to skill procedures for IV insertion, emergency oxygen administration, and airway obstruction with competency testing. The Director of Nursing or Unit Manager for hall one will provide training to all licensed nurses on IV insertion, emergency oxygen administration and airway obstruction with competency testing. No staff will work after 12/19/2013 without having received this education and validation competency</p> <p>4. The Director of Nursing will audit five (5) resident records per week for twelve (12) weeks to ensure that the care plans meet the needs of the resident and care plan interventions are followed. All monitoring will be reviewed weekly by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Social Services Director, Unit Managers for hall one and two, and Dietary Services Manager and</p>		

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F 282	Continued From page 39 500 milligrams (mg) three times a day (TID); however, RN #1 failed to follow the care plan for meds/treatments as ordered as she did not initiate the IV per the physician's order. Further record review and interview revealed there was no documented evidence RN #1 monitored Resident #1's vital signs; monitored for signs and symptoms of dehydration, monitored for any further change in level of consciousness, monitored for shortness of breath, and obtained lung sounds per the resident's care plan from the time she came on duty on 11/29/13 at 7:00 PM until 11/30/13 at at 7:30 AM. Licensed Practical Nurse (LPN) #1 (the day shift nurse) arrived at the facility and when she entered Resident #1's room at 7:30 AM she noted Resident #1 was having difficulty breathing, the resident's feet, knees and hands were mottled and Resident #1 was not responding. LPN #1 initiated oxygen (O2) at two (2) liters. The resident's blood pressure (B/P) was 55/24 (normal range is 120/70), O2 saturation was 81% (normal range 98-100%) before O2 started, Resident #1 was mouth breathing, pulse was 47 (normal range 70), respirations were 24 (normal 20), and temperature was 97.1 (normal 98.6). The physician was called and the resident was sent to the emergency room for evaluation. The resident was diagnosed with Respiratory Failure, Dehydration, Hypotension and Gastrointestinal Bleeding per rectum. Resident #1 was admitted to the Intensive Care Unit, Coded and passed away at 4:42 PM. Review of the Resident #1's Death Certificate received 01/13/14, dated 12/16/13, revealed the immediate cause of death was Pneumonia, secondary to General Debility with the underlying cause of Alzheimer's Disease. The facility's failure to provide care according to	F 282	the Medical Director attending at least Quarterly.	01/24/14	

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F 282	<p>Continued From page 40</p> <p>the plan of care has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 12/13/13, and was determined to exist on 11/30/13. The facility was notified of the Immediate Jeopardy on 12/13/13. An acceptable Allegation of Compliance (AoC) was received on 12/19/13 and the State Survey Agency validated the Immediate Jeopardy was removed on 12/20/13, as alleged. A partial extended survey was conducted on 12/20/13. 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 monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 01/21/14 at 4:10 PM revealed the facility did not have a policy/procedure that addressed the implementation of the care plan by staff.</p> <p>Record review revealed the facility admitted Resident #1 on 12/31/08 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension (HTN) NOS, Chronic Ischemic Heart Disease, Senile Dementia Uncomplicated, Depressive Disorder NEC, Anemia NOS, Urinary Incontinence NOS, Tuberculosis (TB) of Bronchus, unspecified. Review of the MDS assessment, dated 10/07/13, revealed the facility assessed Resident #1's cognition as severely impaired.</p> <p>Review of Resident #1's Comprehensive Care Plan for Potential for Alteration in Oxygen</p>	F 282			

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F 282	<p>Continued From page 41</p> <p>Exchange and infection related to history of pneumonia and bronchitis, dated 04/16/13, revealed interventions to obtain vital signs as ordered/needed, monitor for signs of dehydration, monitor for change in level of consciousness, monitor for shortness of breath, monitor for cyanosis, lung sounds as ordered/needed, medications/treatments as ordered, report adventitious breath sounds, and update physician as needed.</p> <p>Interview with RN #1, on 12/10/13 at 12:42 PM, on 12/13/13 at 7:36 AM, and on 01/20/14 at 6:00 PM, revealed when she came on duty on 11/29/13 she was told in report that she needed to obtain a UA because Resident #1 was a little lethargic and might have a urinary tract infection. RN #1 stated she had not reviewed Resident #1's care plan but she told CNA #1 to push fluids throughout the night. RN #1 stated CNA #1 reported to her on 11/30/13 at approximately 5:00 AM that Resident #1 was not wanting to take fluids, was having diarrhea, and was not easily aroused. RN #1 stated she assessed Resident #1's vital signs and the resident's blood pressure was "eighty something over fifty something". However, there was no documented evidence RN #1 obtained the resident's vital signs per the plan of care. Per interview, RN #1 called the on-call physician and left a message between 5:30 AM and 6:00 AM. The physician called at 6:00 AM with orders for labs, an x-ray, IV fluids, and medications. However, there was no documented evidence RN #1 provided Resident #1 the medications and treatments ordered by the physician per the resident's plan of care. RN #1 stated she did not start the IV because "Resident #1 was dehydrated, wasn't drinking" and she did not have a lot of experience with starting an IV on</p>	F 282			

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F 282	<p>Continued From page 42</p> <p>someone that was dehydrated. However, per interview and record review, RN #1 failed to update the physician, per the plan of care, that she was unable to start the IV fluids. The RN stated she looked in on the resident around 6:30 AM and he/she was asleep. She stated the resident opened his/her eyes but RN #1 did not take his/her vital signs or assess the resident.</p> <p>Further record review which included the Nurses Notes and Interdisciplinary Team Notes, dated 11/29/13 and 11/30/13, revealed there was no documented evidence Resident #1's interventions related to the resident's history of pneumonia and bronchitis were implemented from 11/29/13 at 7:00 PM through 11/30/13 at 7:30 AM when LPN #1 (day shift nurse) went to Resident #1's room.</p> <p>Interview with LPN #1, on 12/10/13 at 10:30 AM and 12/12/13 at 4:10 PM, revealed when she entered Resident #1's room the resident was pale, was not responding to staff, and would moan when touched. The resident's vital signs were abnormal and the resident's extremities were mottling. She stated the resident's O2 sat was 81%, so she obtained an oxygen (O2) concentrator and placed the resident on O2 at two (2) liters per minute per nasal cannula. LPN #1 stated she called the physician at approximately 7:30 AM to send the resident to the hospital with no response and she called the physician again at 8:00 AM-8:15 AM and received an order to send the resident to the hospital for evaluation.</p> <p>Review of a Interdisciplinary Team Note, dated 11/30/13 at 1:13 PM, revealed at 7:30 AM, LPN #1 (day shift nurse) entered Resident #1's room and noted Resident #1 was having difficulty</p>	F 282			

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F 282	<p>Continued From page 43</p> <p>breathing, the resident's feet, knees and hands were mottled, and the resident was not responding. The resident's blood pressure (B/P) was 55/24, O2 saturation was 81% before O2 was started and the resident was mouth breathing. LPN #2 placed the resident on oxygen per nasal cannula and LPN #2 (day shift nurse) initiated the IV in the resident's right arm and administered Normal Saline at 90 cc's an hour. The resident's pulse was 47, respirations 24, and temperature was 97.1 degrees Fahrenheit. The physician was called and advised of Resident #1's condition and code status. The Physician stated to send Resident #1 to the emergency room for evaluation.</p> <p>Review of the Hospital Emergency Department Physician Chart, dated 11/30/13, revealed Resident #1 was diagnosed with Respiratory Failure, Dehydration, Hypotension and Gastrointestinal Bleeding per rectum. Review of the Resident #1's Death Certificate, dated 12/16/13, revealed the immediate cause of death was Pneumonia, secondary to General Debility with the underlying cause of Alzheimer's Disease.</p> <p>Interview with the DON, on 01/21/14 at 10:28 AM, revealed she expected the nurse to follow the care plan.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 12/14/13, the Regional Director of Operations re-educated the Administrator related to the responsibility of the Administrator to oversee the facility in accordance with Federal regulations to include monitoring of the Director of Nursing related to the supervision of nursing staff. On</p>	F 282			

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F 282	<p>Continued From page 44</p> <p>12/14/13, the Administrator re-educated the Director of Nursing on the requirements to supervise nursing staff to include guidance and direction for new nurses as well as follow up questions in communications with the nursing staff. On 12/14/13, the Regional Nurse Consultant re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for hall one and two on the Interact Process, timely notification of the physician and using the Medical Director if unable to reach the attending physician timely including calling 911 in an emergency situation. The Interact Process is an evidence based practice program developed at the request of the Centers for Medicaid and Medicare Services to reduce unnecessary return hospitalizations. The Regional Nurse Consultant also re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for units one and two on notification of the physician if the nurse was unable to follow MD orders in a timely manner. It includes suggestions for nurses on when to notify the physician and what recommendations for treatments to make, but does not override the judgement of the nurse at bedside.</p> <p>Resident #1 was discharged from the facility on 11/30/13. All Current residents of the facility have been reviewed by the Interdisciplinary Team (IDT) to include the Director of Nursing, Unit Managers for halls one and two, Assistant Director of Nursing, MDS Coordinator and Social Services Director, to assure that any current resident who is experiencing a significant change in condition had physician notification. Any resident who was deemed to have had a significant change in condition in the past thirty (30) days without physician notification had immediate physician</p>	F 282			

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F 282	<p>Continued From page 45</p> <p>notification. This review included a set of vital signs and visual examination of the resident for apparent acute distress by the Director of Nursing, Assistant Director of Nursing or Unit Managers; and, a review of the medical record for the past thirty (30) days by the IDT. This was completed on 12/14/13.</p> <p>The IDT, which included the Director of Nursing, Unit Managers, MDS Coordinator and Social Services Director, reviewed all current residents' care plans on 12/14/13 to assure that the care plan was up to date and met the needs of the resident, and that the care plan interventions were in place. Any resident whose care plan was not up to date to meet the needs of the resident had the care plan updated. Any interventions not in place were implemented.</p> <p>Beginning 12/14/13, all licensed staff was re-educated on immediate notification of the physician with a significant change in condition using the Interact Process as a guideline, but not to supercede the judgement of the nurse in attendance. In addition, the education included notification of the Medical Director if they were unable to reach the attending physician timely. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this education.</p> <p>Beginning on 12/14/13, all licensed staff was re-educated on the completion of appropriate nursing assessments with follow up based upon the resident's condition with examples of abnormal vital signs, respiratory and gastro-intestinal using the Interact guidelines and</p>	F 282			

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F 282	<p>Continued From page 46</p> <p>pathways as a guide, not to supercede the judgement of the nurses in attendance. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this re-education.</p> <p>On 12/14/13, the Regional Nurse Consultant will provide education to the Director of Nursing and the Unit Manager for hall one related to skill procedures for IV insertion, emergency oxygen administration, and airway obstruction with competency testing. The Director of Nursing or Unit Manager for hall one will provide training to all licensed nurses on IV insertion, emergency oxygen administration and airway obstruction with competency testing. No staff will work after 12/19/13, without having received this education and validation competency.</p> <p>An Ad Hoc Quality Assurance Committee meeting (QPI) was held on 12/14/13 to review the alleged deficient practice as well as the plan for removal to include audits for care plans and care plan interventions to assure care plans meet the needs of the residents and interventions are followed, and all training material presented to licensed staff. The discussion also included training completed for the Administrator and the Director of Nursing and how the facility will monitor corrective actions. In attendance was the Administrator, the Director of Nursing, the Assistant Director of Nursing, Unit Manager, MDS Nurse and the Social Service Director. The Medical Director attended via conference call. No further recommendations were made by the committee. The Quality Assurance Committee will meet weekly to review the removal plan as well</p>	F 282			

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F 282	<p>Continued From page 47</p> <p>as monitoring of actions weekly until substantial compliance is achieved.</p> <p>Monitoring of the allegation of compliance will be conducted by doing the following: The Director of Nursing or Unit Manager for hall one will review the Twenty Four Hour Report and all physician orders daily for two weeks, followed by five times a week for at least ten weeks to assure all changes in condition had appropriate physician notification, assessment and follow up. In addition, the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall one will contact the facility once each shift to review with each nurse any significant changes in resident condition to assure licensed staff are assessing and notifying the physician timely. This will occur daily for two weeks, followed by five times per week for at least ten weeks on each shift. The Administrator will speak with all new nurses within the first thirty (30) days of employment and at least five nurses per month for three months to assure training needs are met as well as to assure communication with the Director of Nursing is open and appropriate. The Director of Nursing will audit five resident records per week for twelve weeks to ensure that the care plans meet the needs of the resident and care plan interventions are followed.</p> <p>All monitoring will be received weekly by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Social Services Director, Unit</p>	F 282			

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F 282	<p>Continued From page 48</p> <p>Managers for hall one and two, the Dietary Services Manager and the Medical Director attending at least quarterly. Failure to comply with any of the above will result in individual re-training and as appropriate disciplinary action. The Center alleges by the above actions that the immediate Jeopardy was abated for all residents on 12/20/13.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Review of an in-service provided to the Administrator on 12/14/13 revealed the Administrator was inserviced on the Administration, Supervision and monitoring of system implementation to understand administrative duties and Federal regulations. The supervision of the DON and other direct reports and the method and frequency of system monitoring.</p> <p>Review of an in-service provided to nursing staff on 12/14/13 revealed it included physician notification regarding a resident change in condition, completion of appropriate nursing assessments and follow up, Interact Process review, notification of the physician, call the Medical Director if unable to reach the attending physician timely and to call 911 in an emergency, with no need to call the physician first.</p> <p>Review of the Regional Director Officer's education of the Administrator revealed the Administrator was educated on 12/14/13 related to monitoring the DON's supervision of the nursing staff to include guidance and direction for new nurses and follow up communication.</p>	F 282			



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F 282	<p>Continued From page 49</p> <p>Review of the Regional Nurse Consultant's re-education of the DON, ADON and Unit Managers for halls one and two on 12/14/13 revealed it included: the Interact Process, timely notification, using the Medical Director, and calling 911 if unable to follow physician orders.</p> <p>Review of all residents' assessments performed on 12/14/13 revealed an assessment was conducted which included vital signs and visual examinations. Physician notification was completed if needed for a change in condition by the DON, ADON and Unit Managers. The results were reviewed by the IDT.</p> <p>Review of inservices conducted on 12/14/13 revealed all staff received the inservices, except for two staff who were off for long extended times. The staff was inserviced by the DON on using the Interact Process and what to do if they were unable to reach the physician. Staff who had not completed the in-service will not work until the in-service has been completed. The Unit Manager on hall one, who is present at the start of each shift, will ensure no one works until they have been in-serviced. The Unit Manager on hall one begins each shift by providing education on the completion of appropriate nursing assessments.</p> <p>Review of the in-service that was provided to the DON on 12/19/13 by the Regional Nurse Consultant revealed it included IV insertion, emergency oxygen, and airway obstruction. The Unit Manager on hall one will ensure staff who have not completed the in-service will not work until in-serviced. Further review revealed all staff had been inserviced. Skills checks were also completed with staff related to IV insertion,</p>	F 282			

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F 282	<p>Continued From page 50</p> <p>emergency oxygen and airway obstruction. All staff scheduled to work after 7:00 PM Sunday had completed the skills check off.</p> <p>Interviews with LPN #1, LPN #2, LPN #3, LPN #4, LPN #5, RN #3 and RN #4 on 12/20/13 at 1:50 PM, 3:35 PM, 3:45 PM, and 4:10 PM, revealed they had been in-serviced related to residents' change in conditions, timely notification of the physician and/or the Medical Director, or to call 911 in an emergency. In addition, the staff revealed they were in-serviced on the Interact Process, accurate chart documentation, IV techniques and oxygen administration in an emergency.</p> <p>Interview with the DON on 12/20/13 at 3:30 PM, revealed she was re-educated on 12/14/13 by the Regional Nurse Consultant which included educating the nurses to ensure they were comfortable with doing their job and completing their skills. In-services included education on documentation, emergency procedures, oxygen administration, physician notification, the Interact Process, and SBAR. The nurses were also strongly encouraged to not let these guidelines override their nursing judgement. The DON stated she will be more involved with nurses so she can identify their skill needs, and what education they may need. She stated the staff was instructed on timely notification, the Interact System, how to treat emergencies as emergencies and to err on the side of caution. The facility's expectation is for physician orders to be implemented and residents be sent out of the facility, if needed. Orders should be done timely and staff should be proactive and prevent emergencies instead of trying to hustle to get a resident out to the hospital. The assessment</p>	F 282			

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F 282	Continued From page 51 process should prevent those emergencies from happening. She stated she assisted the Assistant Director of Nursing and the Unit Manager and assessed all residents to ensure all needs were being met. Vital signs and visual assessments were completed, the information was documented, the charts were reviewed and compared with the care plans. All care plans were updated to ensure the residents' needs were being met. The Process now is to have a daily clinical meeting which includes (DON, ADON, and UM) to review new orders, care plans, and resident conditions. If needed, they will have an afternoon meeting to review anything that needed to be followed up on from the morning meeting. Any resident who had a significant change in the past thirty (30) days without physician notification had immediate physician notification. Further interview revealed medical records were reviewed on all residents for the last thirty (30) days beginning 12/14/13. All licensed staff was re-educated on the immediate notification of the physician with a sudden change in condition using the Interact Process, as a guide. If staff was unable to reach the physician, they may call the Medical Director. If the Medical Director doesn't answer within ten to fifteen minutes to send the resident out to the hospital. The Regional Nurse Consultant provided education to her and the acting ADON/UM for half one. Education included the procedure for picking an IV site and insertion of the IV, follow up assessments every shift, signs and symptoms of infection, notification of the physician and documentation. Oxygen administration which included when to assess and apply, what to start the oxygen at, stay with the resident and to notify the physician to get a order. Competency validation with no staff	F 282			

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F 282	<p>Continued From page 52</p> <p>working after 12/19/13 without having the education and the validated competency. A Quality Assurance meeting was held on 12/14/13, they discussed the concerns and issues with the Medical Director and began making plans of correction that included in-services and education, assessments of residents, updated care plans and significant changes that the physician would need to be notified about. She stated they were monitoring for corrective actions and it was her responsibility to monitor the Twenty Four Hour Reports daily and to call the facility three (3) times a day on each shift to speak with the nurses and get a report on their residents. She stated she reviewed orders and care plans daily in the clinical meeting and she was auditing all admissions. Further interview revealed she would audit five records daily right now to ensure everything was in place then will audit weekly. Monitoring was reviewed by the Quality Assurance team.</p> <p>Interview with the Administrator on 12/20/13 at 4:10 PM, revealed he was re-educated by the Regional Director Officer on 12/14/13. His education included understanding administrative duties, federal regulations, supervision of the Director of Nursing and other direct reports. They also reviewed their method and frequency of system monitoring. He stated he educated the Director of Nursing which included supervision of nursing staff on guidance and direction for all nurses. The education also included information to follow up with and communicate with nursing staff. He reviewed the DON's administrative duties, supervision of direct reports and method and frequency of system monitoring. He stated he was involved in the Quality Assurance meeting on 12/14/13 with the IDT members and the Medical</p>	F 282			

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F 282	Continued From page 53 Director via a conference call. Further interview revealed he reviewed all findings of the Immediate Jeopardy survey and the abatement. He stated he was overseeing audits, twenty four hour reports, physician orders review and daily shift reviews for significant changes in conditions. He stated he is also speaking with all new nurses within thirty (30) days of hire; and, a total of five nurses per month for three months to ensure their training needs were being met and communication with the DON was open and appropriate.	F 282			
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of the Minimum Data Set (MDS) assessment, physician's orders, Comprehensive Care Plan, nursing and Interdisciplinary Team Notes, resident transfer form, Ambulance Service Run Report, hospital physical, laboratory reports, hospital Emergency Department Physician Chart, Death Certificate and facility policy/procedure it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well being, in	F 309	F309 1. Resident # 1 was discharged from the facility on 11-30-2013. 2. On 12/14/2013 all current residents of the facility were reviewed by the Interdisciplinary Team (IDT) to include the Director of Nursing, Unit Managers for halls one and two, Assistant Director of Nursing, MDS Coordinator and Social Services Director to assure that any current resident who is experiencing a significant change in condition had physician notification. Any resident who was deemed to have had a significant change in condition in the past thirty (30) days without physician notification had immediate physician notification. This review included a set of vital signs and visual examination of the resident for apparent acute distress by the Director of Nursing, Assistant Director of Nursing or Unit Managers and a review of the medical record for the past thirty (30) days by the IDT. The IDT, which included the Director of Nursing, Unit Managers for halls one and two and the MDS Coordinator and Social Services Director, reviewed all current residents' care plans on 12/14/2013 to assure that the care plan was up to date and met the needs of the resident, and the care plan interventions were in place. Any resident whose care plan was not up to date to meet the needs of the resident had the care plan updated. Any interventions not in place were implemented.		

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F 309	<p>Continued From page 54</p> <p>accordance with the comprehensive assessment and plan of care for one (1) of five (5) sampled residents (Resident #1).</p> <p>On 11/29/13, when Registered Nurse (RN) #1 came on duty at 7:00 PM, she was made aware Resident #1 was a little lethargic and she needed to obtain a Urinalysis because the physician thought he/she might have a Urinary Tract Infection (UTI). On 11/30/13 at approximately 5:00 AM, a Certified Nurse Aide (CNA) reported to RN #1 that Resident #1 was having diarrhea, did not want to drink and would not arouse easily. RN #1 assessed the resident and called the physician and left a message at approximately 5:30-6:00 AM. RN #1 proceeded to administer other residents' medication while she waited for the return call from the physician. The physician called at 6:00 AM with orders for a Complete Blood Count (CBC), Comprehensive Metabolic Profile (CMP), Urinalysis (UA), chest x-ray, Intravenous Fluids (IV) Normal Saline at 90 cubic centimeters (cc) per hour (hr), and IV Flagyl (antibiotic) 500 milligrams (mg) three times a day (TID). RN #1 failed to provide care according to the care plan related to the physician's orders for the IV which was in the scope of practice of an RN and failed to notify the physician she was unable to initiate the IV. In addition, there was no evidence the RN provided the care and services related to conducting ongoing assessments and monitoring of the resident from 11/29/13 at 7:00 PM when she was made aware of the resident's condition until 11/30/13 at 7:30 AM when the day shift nurse arrived. When Licensed Practical Nurse (LPN) #1 (day shift nurse) went to the resident's room at 7:30 AM to carry out the physician's orders, she noted Resident #1 was having difficulty breathing, the resident's feet,</p>	F 309	<p>3. On 12/14/2013 the Regional Director of Operations re-educated the Administrator related to the responsibility of the Administrator to oversee the facility in accordance with Federal regulations to include monitoring of the Director of Nursing related to the supervision no nursing staff. On 12/14/2013 the Administrator re-educated the Director of Nursing on the requirements to supervise nursing staff to include guidance and direction for new nurses as well as follow up questions in communications with the nursing staff. On 12/14/13 the Regional Nurse Consultant re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for hall one and two on the Interact Process, timely notification of the physician and using the Medical Director if Unable to reach the attending physician timely including calling 911 in an emergency situation. The Interact process is evidence based practice program developed at the request of the Centers for Medicaid and Medicare Services to reduce unnecessary return hospitalizations. The Regional Nurse Consultant also re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for units one and two on notification of the physician if the nurse was unable to follow MD orders in a timely Manner It includes suggestions for nurses on when to notify the physician and what recommendations for treatment to make but does not supercede the judgment of the nurse at bedside.</p> <p>Beginning 12/14/2013, all licensed staff was re-educated on the immediate notification of</p>		

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F 309	<p>Continued From page 55</p> <p>knees and hands were mottled and Resident #1 was not responding. The nurse initiated oxygen (O2) at two (2) liters and conducted an in and out catheterization for urine for the UA. The nurse obtained approximately five to seven cc's of dark tea colored urine. The resident's blood pressure (B/P) was 55/24 (normal range: 120/70), O2 saturation was 81% (normal range: 98-100%) before O2 started, Resident #1 was mouth breathing, pulse was 47 (normal range: 70), respirations were 24 (normal range: 20), and temperature was 97.1 (normal range: 98.7). LPN #2 initiated the IV per the physician's order. The physician was called at 7:30 AM for orders to send the resident to the hospital with no response from the physician. LPN #1 did not call the physician back until 8:00-8:15 AM with orders received to send the resident to the emergency room for evaluation at that time. Resident #1 was diagnosed with Respiratory Failure, Dehydration, Hypotension and Gastrointestinal Bleeding per rectum. Resident #1 was admitted to the Intensive Care Unit, coded and passed away at 4:42 PM.</p> <p>Refer to F157, F281 and F282.</p> <p>The facility's failure to provide the necessary care and services to attain or maintain the highest practical physical, mental and psychosocial well being in accordance with the comprehensive assessment and care plan has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 12/13/13, and was determined to exist on 11/30/13. The facility was notified of the Immediate Jeopardy on 12/13/13. An acceptable Allegation of Compliance (AoC) was received on 12/19/13 and the State Survey Agency validated</p>	F 309	<p>the physician with a significant change in condition using the Interact Process as a guideline, but not to supersede the judgment of the judgment of the nurse in attendance. In addition, the education included notification of the Medical Director if they were unable to reach the attending physician timely. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall one. No licensed staff will work after 12/14/13 without having received this education.</p> <p>Beginning 12/14/2013, all licensed staff was re-educated on the completion of appropriate nursing assessments with follow up based upon the resident's condition with examples of abnormal vital signs, respiratory and gastro-intestinal using the interact guidelines and pathways as a guide, not to supersede the judgment of the nurses in attendance. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this re-education.</p> <p>On 12/14/2013 the Regional Nurse Consultant provided education to the Director of Nursing and the Unit Manager for hall one related to skill procedures for IV insertion, emergency oxygen administration, and airway obstruction with competency testing. The Director of Nursing or Unit Manager for hall one will provide training to all licensed nurses on IV insertion, emergency oxygen administration and airway obstruction with competency testing. No staff will work after 12/19/2013 without having received this education and validation competency</p>		

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F 309	<p>Continued From page 56</p> <p>the Immediate Jeopardy was removed on 12/20/13, as alleged. A partial extended survey was conducted on 12/20/13. 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 monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure "Change in Condition", dated 01/11, revealed a change of condition in a resident should target many areas of the Interdisciplinary Team (IDT) function. To ensure the optimal outcome for the resident, the nursing process of Assessment, Plan, Intervention, and Evaluation will be used. Physician involvement is always required, as is follow-up assessment per Federal Guidelines. Process: Interact 11 system is to be used with this protocol. Change in condition Assessment Guidelines will be followed by the licensed nurse for the initial, and when necessary the follow-up assessment to detect change in condition by symptoms and categories. Interact tool "Immediate Notification" revealed any symptom, sign or apparent discomfort that is acute or sudden in onset, and a marked change (more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. All information triggers in this reference will be used when notifying the physician. A Situation-Background-Assessment/Appearance Request (SBAR) form is to be used for documentation prior to notifying the physician. This form will contain information gathered when doing an assessment and is to be utilized as a Nursing Note in the medical record. Notification</p>	F 309	<p>4. The Director of Nursing or Unit Manger for hall one will review the twenty Four Hour Report and all physician orders daily for two (2) weeks, followed by five (5) times a week for at least ten (10) weeks to assure all changes in condition had appropriate physician notification, assessment and follow up. In addition the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall one will contact the facility once each shift to review with each nurse any significant changes in resident condition to assure licensed staff are assessing and notifying the physician timely. This will occur daily for two (2) weeks, followed by five (5) times per week for at least ten weeks on each shift. The Administrator will speak with all new nurses within the first thirty (30) days of employment and at least five (5) nurses per month for three months to assure training needs are met as well as to assure communication with the Director of Nursing is open and appropriate. The Director of Nursing will audit five (5) resident records per week for twelve (12) weeks to ensure that the care plans meet the needs of the resident and care plan interventions are followed. All monitoring will be reviewed weekly by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Social Services Director, Unit Managers for hall one and two, and Dietary Services Manager and</p>		

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F 309	<p>Continued From page 57</p> <p>of Resident Change In Condition: Clinicians will immediately consult with the resident's physician when there is a significant change in condition. Document in the Nurses' Notes the times notification was made and the names of the person(s) to whom you spoke.</p> <p>Record review revealed the facility admitted Resident #1 on 12/31/08 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension (HTN) NOS, Chronic Ischemic Heart Disease, Senile Dementia Uncomplicated, Depressive Disorder NEC, Anemia NOS, Urinary Incontinence NOS, Tuberculosis (TB) of Bronchus, unspecified. Review of the MDS assessment, dated 10/07/13, revealed the facility assessed Resident #1's cognition as severely impaired. Review of the physician orders, dated 11/01/13 through 11/30/13, revealed Resident #1 was a full code.</p> <p>Review of Resident #1's Comprehensive Care Plan for Potential for Oxygen Exchange, Infection related to incontinence and Nutritional Risk, dated 10/10/13, revealed interventions to obtain vital signs as ordered/needed, O2 as ordered/needed, encourage fluid intake, monitor for signs of dehydration, monitor for change in level of consciousness, monitor for shortness of breath, monitor for cyanosis, lung sound as ordered/needed, Meds/treatments as ordered, report adventitious breath sounds, and update physician as needed.</p> <p>Interview with CNA #1, on 12/13/13 at 7:05 AM, revealed she reported to RN #1, on 11/30/13 at approximately 5:00 AM, Resident #1 was having diarrhea, did not want to drink anything, and was not easily aroused.</p>	F 309	the Medical Director attending at least Quarterly.	01/24/14	

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F 309	<p>Continued From page 58</p> <p>Record review revealed no documented evidence a Situation-Background-Assessment/Appearance Request was completed by RN #1 related to any assessments of Resident #1 by the nurse when a change in condition was identified.</p> <p>Review of a telephone physician order, dated 11/30/13 at 6:00 AM, revealed an order for a Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), and Urinalysis (UA) now, chest x-ray, Normal Saline IV at 90 cc's per hour and Flagyl (antibiotic) 500 mg IV three times a day.</p> <p>Interview with RN #1, on 12/10/13 at 12:42 PM, on 12/13/13 at 7:36 AM, and on 01/20/14 at 6:00 PM revealed when she reported to work on 11/29/13 at 7:00 PM, the off going nurse told her that Resident #1 was a little lethargic and she needed to obtain a Urinalysis because the physician thought he/she might have a Urinary Tract Infection (UTI). She stated she instructed the CNA to push fluids. At 5:00 AM, CNA #1 reported that Resident #1 was having diarrhea and not wanting to take fluids. RN #1 stated around 5:00 AM she assessed Resident #1's vital signs and the resident's blood pressure was "eighty something over fifty something". RN #1 stated she documented the assessment and vital signs on a note pad and threw the note away without documenting the information in the resident's records. She stated she was not aware of the Interact process and did not complete a SBAR per the facility's policy. RN #1 called the on-call physician and left a message between 5:30 AM and 6:00 AM. RN #1 revealed she then administered the morning medications to other residents until the physician called at 6:00 AM</p>	F 309			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/23/2014
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 309	<p>Continued From page 59</p> <p>with orders for labs, an x-ray, IV fluids and medications. The RN stated she did not start the IV because "Resident #1 was dehydrated, wasn't drinking" and she did not have a lot of experience with starting an IV on someone that was dehydrated. Another reason she did not start the IV was due to not having "good feeling" in her fingertips. She stated she had started IV's in the facility in the past but she always had another nurse with her. She stated she asked for assistance a few different times during her shift from RN #2; however, RN #2 could not help due to having issues going on with her residents and she was in the middle of a medication pass. She stated she did not notify the physician she was unable to start the IV fluids. The RN stated everything was happening around 5:00 - 5:30 AM, and she felt overwhelmed. She stated after she received the physician's order at 6:00 AM, she called the Director of Nursing (DON), who was on call after 6:00 AM, to let her know Resident #1 had a change in condition and what the physician ordered. She stated she knew the day shift nurse would be coming in and she told the DON she would ask for help with the IV when the nurse got there. She stated she continued to work on passing her medications. She stated when the day shift LPN (LPN #2) arrived, she flagged her down and told her she needed help to start an IV. LPN #2 then clocked in and started the IV.</p> <p>Interview with LPN #2, on 12/10/13 at 11:47 AM and on 12/12/13 at 4:50 PM revealed she was asked by RN #1 to start Resident #1's IV because RN #1 didn't think she could start it since the resident was dehydrated. She stated she gathered the supplies and started Resident #1's IV around 7:00 AM. Resident #1 did not look good, his/her eyes were sunken and looked</p>	F 309			

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F 309	<p>Continued From page 60</p> <p>dehydrated. She stated she filled out the transfer form around 8:00 AM and the vitals signs and an assessment were conducted before the resident was transferred to the hospital. She stated LPN #1 called the physician and Resident #1 was sent out.</p> <p>Review of an Interdisciplinary Team Note, dated 11/30/13 at 1:13 PM, revealed at 7:30 AM, LPN #1 (day shift nurse) called the mobile x-ray agency for a stat chest x-ray. When LPN #1 entered the resident's room to catheterize Resident #1 to obtain the UA, she observed Resident #1 was having difficulty breathing, the resident's feet, knees and hands were mottled, and the resident was not responding. LPN #1 initiated O2 at two (2) liters, and obtained urine with an in and out catheter. She was able to obtain approximately five (5) to seven (7) cc's of dark tea colored urine. The resident's blood pressure (B/P) was 55/24, O2 saturation was 81% before O2 was started and the resident was mouth breathing. LPN #2 initiated the IV in the resident's right arm and administered Normal Saline at 90 cc's an hour. The resident's pulse was 47, respirations 24, and temperature was 97.1 degrees Fahrenheit. The physician was called and advised of Resident #1's condition and code status. The Physician stated to send Resident #1 to the emergency room for evaluation.</p> <p>Interview with LPN #1, on 12/10/13 at 10:30 AM and 12/12/13 at 4:10 PM, revealed she walked in at shift change and was told an IV needed to be started. She stated RN #1 told her Resident #1 wasn't doing well. She stated she could see RN #1 was really overwhelmed, behind and she started helping. She stated when she entered</p>	F 309			

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F 309	<p>Continued From page 61</p> <p>Resident #1's room she noted Resident #1 was pale, was not responding to staff, and would moan when touched. She stated the resident's vital signs were abnormal and the resident's extremities were mottling. She stated the resident's O2 sat was 81%, so she obtained an oxygen (O2) concentrator and placed the resident on O2 at two (2) liters per minute per nasal cannula. LPN #1 stated she called the physician at approximately 7:30 AM to send the resident to the hospital with no response and she called the physician again at 8:00 AM-8:15 AM and received an order to send the resident to the hospital for evaluation.</p> <p>Review of the physician telephone order, dated 11/30/13 at 8:15 AM, revealed an order to send Resident #1 to the Emergency Room (ER) for evaluation.</p> <p>Review of a transfer form, dated 11/30/13 (no time) filled out by LPN #1, revealed the reason for transfer was decreased oxygen saturation, B/P 63/25, pulse 0-43, O2 sat 72%, mottling of hands, feet and knees, and dehydration. An IV of normal saline was started at 7:00 AM at 90 ccs per hour. The Physician was notified of Resident #1's change in condition and oxygen saturation continued dropping.</p> <p>Review of the Ambulance Service Run Report and narrative, dated 11/30/13, revealed a call was received from the facility at 8:22 AM with the chief complaint that Resident #1 was unresponsive. The ambulance arrived at the facility at 8:28 AM and the attendants were at Resident #1's side at 8:30 AM. Initial assessment revealed Resident #1 was unresponsive, cold and pale, the left and right pupil were 2-mm non-reactive, lung sounds</p>	F 309			

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F 309	<p>Continued From page 62</p> <p>of the left and right upper and lower lungs were decreased, and the resident was incontinent with diarrhea. The resident's brachial pulse, femoral pulse, pedal pulse and radial pulse were absent. The facility staff had started O2 and an IV 24 gauge with normal saline was in place but was not running. The resident was unresponsive and nursing staff was at bedside. Vital signs were checked, they were unable to obtain B/P, the carotid pulse was present but very weak. They were unable to obtain SPO2 (oxygen saturation) due to cold extremities. They increased O2 to non rebreather mask at 15 liters per minute. They established IV 20 ga to left forearm with Normal saline 0.9% initiated at open rate. They established a second IV to the left antecubal with Normal saline 0.9% at open rate. The resident's skin was pale, cool and dry with poor skin turgor. Respirations were shallow and rapid, lung sounds were diminished in both upper and lower lobes. They were unable to palpate distal pulses.</p> <p>Review of the hospital physical, dated 11/20/13 at 8:30 AM, revealed Resident #1 had dry mucus membranes, was hypoxic (lack of oxygen), pale and unresponsive. Review of the Hospital Laboratory Report, dated 11/30/13 at 9:00 AM, revealed Resident #1's BUN (Blood, Urea, Nitrogen) was 149 (reference range 7-18) and Creatinine 7.6 (reference range 0.8-1.4). Review of the Hospital Emergency Department Physician charting, dated 11/30/13, revealed Resident #1 was diagnosed with Respiratory Failure, Dehydration, Hypotension and Gastrointestinal Bleeding per rectum. Interview with the Hospital Social Worker, on 12/10/13 at 9:03 AM, revealed the resident was admitted to the Intensive Care Unit, Coded and passed away at 4:42 PM. Review of Resident #1's Death Certificate</p>	F 309			

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F 309	<p>Continued From page 63</p> <p>received 01/13/14, dated 12/16/13, revealed the immediate cause of death was Pneumonia, secondary to General Debility with the underlying cause of Alzheimer's Disease.</p> <p>Interview with Resident #1's physician, on 12/10/13 at 3:56 PM, revealed Resident #1 had diarrhea with a blood pressure that had dropped. Resident #1 was intubated due to respiratory distress and he/she had pneumonia.</p> <p>Interview with the Director of Nursing (DON), on 12/11/13 at 2:15 PM, on 12/12/13 at 5:15 PM; and, on 12/13/13 at 3:05 PM, revealed if the nurse was unable to reach a provider, the nurse should re-call the physician and should try again within thirty (30) minutes. She stated there was no policy with a specific time, nursing was to use their judgement. She stated there was no documentation as to the time the physician was called. The DON revealed she would have expected the nurse to initiate the IV immediately. The DON stated she was on call and the nurses call whoever is on call related to any incidents, changes in condition and keep them updated on what is going on in the home. She stated when RN #1 called her the second time she was preparing to come in to the facility and she got to the facility at 9:00 AM. She stated the nurses can call administrative staff anytime they have issues and we will come in. The DON stated she did not feel like she needed to hurry up and go in. She stated RN #1 could have asked RN #2 to assist, called the IV Team or sent Resident #1 to the hospital. She stated she was not sure if RN #1 asked for assistance to start the IV. She stated she received a call from RN #1 at 6:30 AM with an update about transfers and the RN had told her Resident #1 wasn't doing well. RN #1 stated</p>	F 309			

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F 309	<p>Continued From page 64</p> <p>she had received orders from the physician for an IV, stat labs and chest x-ray, UA and antibiotics. The DON stated RN #1 never said she was overwhelmed and needed help. The DON stated she did not ask RN #1 if she needed help. She stated she then received a call around 8:00 AM to 8:45 AM about Resident #1 being sent out per 911 emergency from LPN #1. The DON revealed RN #1 was a fairly new nurse and had worked at the facility six to seven months. She stated RN #1 had completed orientation; however; there was no competency for IV's. She stated the RN was trained on the Interact system and how to use the SBAR to document resident assessment findings so when the physician was called the information could be relayed to the physician.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 12/14/13, the Regional Director of Operations re-educated the Administrator related to the responsibility of the Administrator to oversee the facility in accordance with Federal regulations to include monitoring of the Director of Nursing related to the supervision of nursing staff. On 12/14/13, the Administrator re-educated the Director of Nursing on the requirements to supervise nursing staff to include guidance and direction for new nurses as well as follow up questions in communications with the nursing staff. On 12/14/13, the Regional Nurse Consultant re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for half one and two on the Interact Process, timely notification of the physician and using the Medical Director if unable to reach the attending physician timely including calling 911 in an emergency situation. The Interact Process is an</p>	F 309			

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F 309	<p>Continued From page 65</p> <p>evidence based practice program developed at the request of the Centers for Medicaid and Medicare Services to reduce unnecessary return hospitalizations. The Regional Nurse Consultant also re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for units one and two on notification of the physician if the nurse was unable to follow MD orders in a timely manner. It includes suggestions for nurses on when to notify the physician and what recommendations for treatments to make, but does not override the judgement of the nurse at bedside.</p> <p>Resident #1 was discharged from the facility on 11/30/13. All Current residents of the facility have been reviewed by the Interdisciplinary Team (IDT) to include the Director of Nursing, Unit Managers for halls one and two, Assistant Director of Nursing, MDS Coordinator and Social Services Director, to assure that any current resident who is experiencing a significant change in condition had physician notification. Any resident who was deemed to have had a significant change in condition in the past thirty (30) days without physician notification had immediate physician notification. This review included a set of vital signs and visual examination of the resident for apparent acute distress by the Director of Nursing, Assistant Director of Nursing or Unit Managers; and, a review of the medical record for the past thirty (30) days by the IDT. This was completed on 12/14/13.</p> <p>The IDT, which included the Director of Nursing, Unit Managers, MDS Coordinator and Social Services Director, reviewed all current residents' care plans on 12/14/13 to assure that the care plan was up to date and met the needs of the</p>	F 309			

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F 309	<p>Continued From page 66</p> <p>resident, and that the care plan interventions were in place. Any resident whose care plan was not up to date to meet the needs of the resident had the care plan updated. Any interventions not in place were implemented.</p> <p>Beginning 12/14/13, all licensed staff was re-educated on immediate notification of the physician with a significant change in condition using the Interact Process as a guideline, but not to supercede the judgement of the nurse in attendance. In addition, the education included notification of the Medical Director if they were unable to reach the attending physician timely. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this education.</p> <p>Beginning on 12/14/13, all licensed staff was re-educated on the completion of appropriate nursing assessments with follow up based upon the resident's condition with examples of abnormal vital signs, respiratory and gastro-intestinal using the interact guidelines and pathways as a guide, not to supercede the judgement of the nurses in attendance. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this re-education.</p> <p>On 12/14/13, the Regional Nurse Consultant will provide education to the Director of Nursing and the Unit Manager for hall one related to skill procedures for IV insertion, emergency oxygen administration, and airway obstruction with</p>	F 309			

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F 309	<p>Continued From page 67</p> <p>competency testing. The Director of Nursing or Unit Manager for hall one will provide training to all licensed nurses on IV insertion, emergency oxygen administration and airway obstruction with competency testing. No staff will work after 12/19/13, without having received this education and validation competency.</p> <p>An Ad Hoc Quality Assurance Committee meeting (QPI) was held on 12/14/13 to review the alleged deficient practice as well as the plan for removal to include audits for care plans and care plan interventions to assure care plans meet the needs of the residents and interventions are followed, and all training material presented to licensed staff. The discussion also included training completed for the Administrator and the Director of Nursing and how the facility will monitor corrective actions. In attendance was the Administrator, the Director of Nursing, the Assistant Director of Nursing, Unit Manager, MDS Nurse and the Social Service Director. The Medical Director attended via conference call. No further recommendations were made by the committee. The Quality Assurance Committee will meet weekly to review the removal plan as well as monitoring of actions weekly until substantial compliance is achieved.</p> <p>Monitoring of the allegation of compliance will be conducted by doing the following: The Director of Nursing or Unit Manager for hall one will review the Twenty Four Hour Report and all physician orders daily for two weeks, followed by five times a week for at least ten weeks to assure all changes in condition had appropriate physician notification, assessment and follow up. In addition, the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall one</p>	F 309			

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F 309	<p>Continued From page 68</p> <p>will contact the facility once each shift to review with each nurse any significant changes in resident condition to assure licensed staff are assessing and notifying the physician timely. This will occur daily for two weeks, followed by five times per week for at least ten weeks on each shift. The Administrator will speak with all new nurses within the first thirty (30) days of employment and at least five nurses per month for three months to assure training needs are met as well as to assure communication with the Director of Nursing is open and appropriate. The Director of Nursing will audit five resident records per week for twelve weeks to ensure that the care plans meet the needs of the resident and care plan interventions are followed.</p> <p>All monitoring will be received weekly by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Social Services Director, Unit Managers for hall one and two, the Dietary Services Manager and the Medical Director attending at least quarterly. Failure to comply with any of the above will result in Individual re-training and as appropriate disciplinary action. The Center alleges by the above actions that the immediate Jeopardy was abated for all residents on 12/20/13.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Review of an in-service provided to the</p>	F 309			

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F 309	<p>Continued From page 89</p> <p>Administrator on 12/14/13 revealed the Administrator was inserviced on the Administration, Supervision and monitoring of system implementation to understand administrative duties and Federal regulations. The supervision of the DON and other direct reports and the method and frequency of system monitoring.</p> <p>Review of an in-service provided to nursing staff on 12/14/13 revealed it included physician notification regarding a resident change in condition, completion of appropriate nursing assessments and follow up, Interact Process review, notification of the physician, call the Medical Director if unable to reach the attending physician timely and to call 911 in an emergency, with no need to call the physician first.</p> <p>Review of the Regional Director Officer's education of the Administrator revealed the Administrator was educated on 12/14/13 related to monitoring the DON's supervision of the nursing staff to include guidance and direction for new nurses and follow up communication.</p> <p>Review of the Regional Nurse Consultant's re-education of the DON, ADON and Unit Managers for halls one and two on 12/14/13 revealed it included: the Interact Process, timely notification, using the Medical Director, and calling 911 if unable to follow physician orders.</p> <p>Review of all residents' assessments performed on 12/14/13 revealed an assessment was conducted which included vital signs and visual examinations. Physician notification was completed if needed for a change in condition by the DON, ADON and Unit Managers. The results</p>	F 309			

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F 309	<p>Continued From page 70 were reviewed by the IDT.</p> <p>Review of inservices conducted on 12/14/13 revealed all staff received the inservices, except for two staff who were off for long extended times. The staff was inserviced by the DON on using the Interact Process and what to do if they were unable to reach the physician. Staff who had not completed the in-service will not work until the in-service has been completed. The Unit Manager on hall one, who is present at the start of each shift, will ensure no one works until they have been in-serviced. The Unit Manager on hall one begins each shift by providing education on the completion of appropriate nursing assessments.</p> <p>Review of the in-service that was provided to the DON on 12/19/13 by the Regional Nurse Consultant revealed it included IV insertion, emergency oxygen, and airway obstruction. The Unit Manager on hall one will ensure staff who have not completed the in-service will not work until in-serviced. Further review revealed all staff had been inserviced. Skills checks were also completed with staff related to IV insertion, emergency oxygen and airway obstruction. All staff scheduled to work after 7:00 PM Sunday had completed the skills check off.</p> <p>Interviews with LPN #1, LPN #2, LPN #3, LPN #4, LPN #5, RN #3 and RN #4 on 12/20/13 at 1:50 PM, 3:35 PM, 3:45 PM, and 4:10 PM, revealed they had been in-serviced related to residents' change in conditions, timely notification of the physician and/or the Medical Director, or to call 911 in an emergency. In addition, the staff revealed they were in-serviced on the Interact Process, accurate chart documentation, IV</p>	F 309			

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

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 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/23/2014
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420		
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F 309	<p>Continued From page 71</p> <p>techniques and oxygen administration in an emergency.</p> <p>Interview with the DON on 12/20/13 at 3:30 PM, revealed she was re-educated on 12/14/13 by the Regional Nurse Consultant which included educating the nurses to ensure they were comfortable with doing their job and completing their skills. In-services included education on documentation, emergency procedures, oxygen administration, physician notification, the Interact Process, and SBAR. The nurses were also strongly encouraged to not let these guidelines override their nursing judgement. The DON stated she will be more involved with nurses so she can identify their skill needs, and what education they may need. She stated the staff was instructed on timely notification, the Interact System, how to treat emergencies as emergencies and to err on the side of caution. The facility's expectation is for physician orders to be implemented and residents be sent out of the facility, if needed. Orders should be done timely and staff should be proactive and prevent emergencies instead of trying to hustle to get a resident out to the hospital. The assessment process should prevent those emergencies from happening. She stated she assisted the Assistant Director of Nursing and the Unit Manager and assessed all residents to ensure all needs were being met. Vital signs and visual assessments were completed, the information was documented, the charts were reviewed and compared with the care plans. All care plans were updated to ensure the residents' needs were being met. The Process now is to have a daily clinical meeting which includes (DON, ADON, and UM) to review new orders, care plans, and resident conditions. If needed, they will</p>	F 309			

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F 309	Continued From page 72 have an afternoon meeting to review anything that needed to be followed up on from the morning meeting. Any resident who had a significant change in the past thirty (30) days without physician notification had immediate physician notification. Further interview revealed medical records were reviewed on all residents for the last thirty (30) days beginning 12/14/13. All licensed staff was re-educated on the immediate notification of the physician with a sudden change in condition using the Interact Process, as a guide. If staff was unable to reach the physician, they may call the Medical Director. If the Medical Director doesn't answer within ten to fifteen minutes to send the resident out to the hospital. The Regional Nurse Consultant provided education to her and the acting ADON/UM for half one. Education included the procedure for picking an IV site and insertion of the IV, follow up assessments every shift, signs and symptoms of infection, notification of the physician and documentation. Oxygen administration which included when to assess and apply, what to start the oxygen at, stay with the resident and to notify the physician to get a order. Competency validation with no staff working after 12/19/13 without having the education and the validated competency. A Quality Assurance meeting was held on 12/14/13, they discussed the concerns and issues with the Medical Director and began making plans of correction that included in-services and education, assessments of residents, updated care plans and significant changes that the physician would need to be notified about. She stated they were monitoring for corrective actions and it was her responsibility to monitor the Twenty Four Hour Reports daily and to call the facility three (3) times a day on each shift to speak with	F 309			

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F 309	<p>Continued From page 73</p> <p>the nurses and get a report on their residents. She stated she reviewed orders and care plans daily in the clinical meeting and she was auditing all admissions. Further interview revealed she would audit five records daily right now to ensure everything was in place then will audit weekly. Monitoring was reviewed by the Quality Assurance team.</p> <p>Interview with the Administrator on 12/20/13 at 4:10 PM, revealed he was re-educated by the Regional Director Officer on 12/14/13. His education included understanding administrative duties, federal regulations, supervision of the Director of Nursing and other direct reports. They also reviewed their method and frequency of system monitoring. He stated he educated the Director of Nursing which included supervision of nursing staff on guidance and direction for all nurses. The education also included information to follow up with and communicate with nursing staff. He reviewed the DON's administrative duties, supervision of direct reports and method and frequency of system monitoring. He stated he was involved in the Quality Assurance meeting on 12/14/13 with the IDT members and the Medical Director via a conference call. Further interview revealed he reviewed all findings of the Immediate Jeopardy survey and the abatement. He stated he was overseeing audits, twenty four hour reports, physician orders review and daily shift reviews for significant changes in conditions. He stated he is also speaking with all new nurses within thirty (30) days of hire; and, a total of five nurses per month for three months to ensure their training needs were being met and communication with the DON was open and appropriate.</p>	F 309		