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OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185142	A. BUILDING _____ B. WING _____	C 02/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR HEALTH CARE CENTER	401 INDIANA AVE MAYFIELD, KY 42066

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F 000	INITIAL COMMENTS	F 000		

An abbreviated/partial extended survey investigating Complaint #KY21295 was conducted on 02/06/14 through 02/19/14 to determine the facility's compliance with Federal requirements. #KY21295 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 02/11/14, and determined to exist on 01/31/14, at 42 CFR 483.20 Resident Assessment, F-282 and 42 CFR 483.25 Quality of Care, F-309, at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25, Quality of Care. The facility was notified of the Immediate Jeopardy on 02/11/14.

On 01/16/14, Resident #1 started chemotherapy for gastric cancer. The care plan included to monitor for signs/symptoms of infection, increased temperature, nausea, vomiting, diarrhea, and abdominal cramping. The resident began having nausea, vomiting, diarrhea, and a temperature of 101.8 degrees Farenheit (F) on 01/27/14. New orders were received from the resident's primary physician to include Tylenol 650 milligrams (mg) suppository every six (6) hours as needed for an increased temperature. Labwork was collected on 01/30/14 with results received on 01/31/14, indicating a low white blood cell count of 0.9 (normal 4.0-10.0). The resident was moved to a private room at this time on reverse isolation precautions, as a nursing intervention. On 01/31/14 at 5:29 PM, the Certified Nurse Aide documented the resident had a temperature of 100.5 degrees F. and made the nurse aware of the temperature; however, there was no documented evidence licensed staff assessed the resident or administered medication for the temperature at that time. Furthermore,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/11/14

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

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F 000	Continued From page 1 there was no documented evidence the licensed nurses conducted ongoing assessments for the remainder of the shift (till 11:00 PM) on 01/31/14 and on the next shift from 11:00 PM until 7:00 AM on 02/01/14. The resident was found in bed deceased on 02/01/14 at 8:00 AM with visible signs of rigor mortis. An acceptable Allegation of Compliance (AoC) was received on 02/18/14 alleging the removal of Immediate Jeopardy on 02/19/14. The State Survey Agency validated, on 02/19/14, the Immediate Jeopardy was removed on 02/19/14, as alleged. The scope and severity was lowered to a "D" at 482.20 Resident Assessment, F-282 and 485.25 Quality of Care, F-309 while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 282 SS=J	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 interview, record review, and review of the Hospital's Office Follow-up Report, and the facility's Condition Change of a Resident policy, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for one (1) of seven (7) sampled residents	F 282	Resident #1 no longer resides at the facility. On February 3, 2014 the Director of Nursing conducted assessment education with the Licensed nurse who provided care for resident #1, including assessments for gastrostomy tube verification, gastric residual checks, and flushing of gastrostomy tubes. A review of the care plans for resident #1 and facility interview with the licensed nurse revealed she did follow the plan of care, but failed to document all her assessment and monitoring information. The following information has been placed with the resident record and the Licensed nurse was reeducated on her documentation skills on Feb 3, 2014. On the nightshift beginning at 2300 on January 31, 2014 at approx 11:30pm the licensed nurse entered resident #1 room and checked the resident O2 saturation with a reading of 96%. At that time resident #1 was sitting up on the side of the bed wearing a t-shirt. The licensed nurse did not check the tube feeding for placement or residual at that time, as no medications were due and the tube feeding was running at the time. At that time the LN asked the resident if resident #1 was ok and resident #1 replied yes. The resident did not complain of any nausea/vomiting/diarrhea, no abdominal cramping, no fatigue, and no complaints of pain.	02/24/14

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F 282	Continued From page 2	F 282	*This Plan of Correction is the center's credible allegation of compliance.*	

(Resident #1). The facility failed to monitor Resident #1 according to the care plan while receiving chemotherapy treatment.

On 01/16/14, Resident #1 started chemotherapy for gastric cancer. The care plan included to monitor for an increased temperature, signs/symptoms of infection, nausea, vomiting, diarrhea, abdominal cramping, increased fatigue, sores in the mouth, sore tongue, skin breakdown, and signs/symptoms of dehydration while receiving chemotherapy. On 01/31/14 at 5:29 PM, the facility documented the resident had a temperature of 100.5 degrees Farenheit (F); however, there was no documented evidence the licensed staff monitored the resident according to the care plan at that time or throughout the remainder of the shift. In addition, there was no documented evidence the resident was monitored on the next shift (on 02/01/14 11:00 PM-7:00 AM). The resident was found in bed deceased, on 02/01/14 at 8:00 AM with visible signs of rigor mortis.

The facility's failure to ensure each resident was provided services by qualified persons in accordance with each resident's written plan of care has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/11/14 and determined to exist on 01/31/14. The facility was notified of the Immediate Jeopardy on 02/11/14. An acceptable Allegation of Compliance (AoC) was received on 02/18/14 alleging the removal of Immediate Jeopardy on 02/19/14. The State Survey Agency validated, on 02/19/14, the Immediate Jeopardy was removed on 02/19/14, as alleged. The scope and severity was lowered to a "D" at 482.20 Resident

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

The licensed nurse noted no shortness of air, heard no audible wheezing and noted the resident had no cough.
The licensed nurse observed the resident gastrostomy tube site and assessed the dressing to be clean and dry. The licensed nurse also assessed visually the abdomen was not distended. The licensed nurse assessed the resident to have no signs or symptoms of dehydration as evidenced by observing moist lips and mouth. The licensed nurse also noted the resident's skin to be warm and supple when she palpated resident #1 hand. The licensed nurse also assessed the resident's tracheostomy to be clean and at midline. These findings were documented as completed on the Medication and Treatment Record by the licensed nurse on 2-1-14.
Shortly after 11:30pm- The CNA reported to the licensed nurse obtaining a tympanic temperature of approx 98 degrees. The CNA also told the licensed nurse the resident wanted the feeding pump off due to feeling full. Due to the resident not having any complaints shortly before when the licensed nurse was in the resident room, and the licensed nurse knowing the resident had a history of

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F 282	Continued From page 3 Assessment, F-282 and 485.25 Quality of Care, F-309 while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes. The findings include: Review of the facility's Condition Change of a Resident policy, last revised 10/31/06, revealed staff was to monitor and assess the resident's condition and response to interventions until stable. Record review revealed the facility admitted Resident #1 on 05/24/13 with diagnoses which included Malignant Neoplasm of the stomach, head/neck mass, Malignant Neoplasm of the mandible, Gastrostomy, and Tracheostomy. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/24/13, revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIM) score of "14" indicating the resident was interviewable. Review of the Comprehensive Care Plan for Chemotherapy, initiated 07/17/13, revealed the nurses needed to monitor the resident for signs and symptoms of infections, nausea, vomiting, diarrhea, abdominal cramping, increased fatigue, sores in the mouth, sore tongue, skin breakdown, and signs/symptoms of dehydration while having chemotherapy. Review of the Hospital's Office Follow-up Report, dated 01/16/14, revealed Resident #1 began treatment for Gastric Carcinoma on 01/16/14.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* dictating when the pump was on/off and the resident being known at times to just turn it off by self, this did not cause concern for the licensed nurse. At approx 3:30am- the licensed nurse entered the resident #1 room and noted the resident to be turned facing the window with arms up under the pillow. The resident appeared to be sleeping. The licensed nurse turned the tube feeding pump on at that time. The licensed nurse did not want to disturb the resident because she knew the resident was ill and needed rest so therefore she did not turn on the light or arouse resident #1. On February 12, 2014, the Director of Nursing Services and the Consultant Pharmacist audited all in-house residents for physician orders for any other residents receiving chemotherapeutic agents to validate evidence of accurate, thorough and timely documentation of clinical assessments and monitoring for medication side effects. No other residents were receiving any chemotherapeutic agents. On February 12, 2014, Nursing Administration to consist of ***Director of Nursing Services, Unit Managers, Minimum Data Set Coordinators***	

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F 282	Continued From page 4 Review of the Nurse's Notes, dated 01/27/14 at 10:30 PM, revealed the resident was complaining of nausea, vomiting and diarrhea and had a temperature of 101.8 degrees F. The physician was notified with new orders received for Phenergan (anti-nausea) suppositories for the nausea, and Tylenol suppositories for the increased temperature. On 01/31/14 at 2:27 PM, the resident was moved to a private room to protect him/her from other people due to a low blood count. The resident was still complaining of nausea and vomiting. Review of the Weights and Vital Signs Summary, revealed Resident #1 had a temperature of 98.3 degrees F. orally on 01/30/14 at 11:09 PM, 99.3 degrees F. tympanic on 01/31/14 at 2:26 PM and an increased temperature of 100.5 degrees F orally (normal 97.3-98.7 orally) on 01/31/14 at 5:29 PM. Record review revealed there was no documented evidence the LPN addressed the resident's increased temperature and no documented evidence the nurse monitored the resident for signs and symptoms of infections, nausea, vomiting, diarrhea, abdominal cramping, increased fatigue, sores in the mouth, sore tongue, skin breakdown, and signs/symptoms of dehydration per care plan at that time or throughout the remainder of the shift on 01/31/14. In addition, there was no documented evidence the licensed staff monitored the resident from 01/31/14 at 11:00 PM through 02/01/14 at 7:00 AM. Review of the Nurse's Notes, dated 02/01/14 at 8:00 AM, revealed the resident was found in bed deceased with signs of lividity, blood pooling in	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ***Registered Nurses and Licensed Practical Nurses*** audited all in-house resident care plan interventions related to chemotherapeutic medications to ensure the interventions are appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. Any medication intervention identified as not having been implemented was implemented immediately. No other residents have a chemotherapeutic care plan. On February 18, 2014, all current residents were assessed head to toe by the ***Director of Nursing, Unit Managers, Case Management, Staff Development Coordinator and a RN***. All current resident care plans were reviewed to ensure that the interventions are appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. On February 10, 2014, the ***Registered Nurse Staff Development Coordinator and/or the Director of Nursing Services, and/or Unit Managers***, initiated education with all Licensed Nurses related to use of the SBAR/ Interact program for identification of resident changes in condition. The assessment and care plan education consisted of:	

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F 282	Continued From page 5 the lowest parts of the body with darkening of the skin in the independent parts of his/her body. In addition, it was noted rigor had set in as illustrated by the fixed position of the resident's limbs. Interview with Licensed Practical Nurse (LPN) #5, on 02/11/14 at 3:00 PM, revealed he was the 3-11 PM shift nurse, on 01/31/14. LPN #5 stated he talked to the resident around 6:00 PM when he was checking the resident's feeding tube for placement and residual prior to starting the tube feeding. He stated at that time the resident had no complaints. He stated he was made aware the resident had a temperature of 100.5 degrees F later in the shift; however, the resident refused a Tylenol suppository. He stated he was supposed to document the refusal on the back of the MAR; however, review of the MAR, dated January 2014, revealed no evidence of the resident's refusal of the medications. Interview with Certified Nurse Aide (CNA) #8, on 02/11/14 at 1:55 PM, revealed she worked on 01/31/14 from 11:00 PM to 7:00 AM. She obtained the resident's temperature at the beginning of the shift; however, she could not remember the results. There was no documented evidence of the temperature. Interview with LPN #1, on 02/06/14 at 2:40 PM and on 02/10/14 at 10:50 AM, revealed she was the nurse on 01/31/14 from 11:00 PM to 7:00 AM. She stated she visualized the resident at the beginning of her shift around 11:00 PM and the resident had an oxygen saturation of 96 percent (%). She stated she asked the resident how he/she was feeling and the resident responded "the same". She stated she did not assess the	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* • Interact III Critical Pathways • use of shift reports to communicate resident status • follow up assessment and monitoring of residents with a change in condition using an alert charting system • PRO 61003-01 Condition Change of a Resident • TL 6103-09 Reporting Change in Condition to the Physician Education will be ongoing until all licensed nurses have attended. Any licensed nurse that has not received the education by February 13, 2014 will not be allowed to work until receiving the education. On February 12, 2014 the ***Registered Nurse Staff Development Coordinator and/or Director of Nursing Services, and/or Unit Managers*** initiated additional assessment and care plan education with all Licensed Nurses related to: • Use of the Omnicare Pharmacy website to look up medication side effects • observing for side effects of medications	

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F 282	Continued From page 7 use of the facility's Pharmacy website to look up side effects of medications, observing for side effects, updating the resident care plans with serious side effects for high risk medications, and reporting to the physician serious medication side effects. Education would be ongoing until all licensed nurses had attended. Any licensed nurse that had not received the education by 02/13/14, would not be allowed to work until receiving the education. - On 02/12/14, the DON also implemented a 72 hour Alert Charting tool as a guide to document evidence of resident assessment and following the care plan. The RN Staff Development Coordinator and/or DON, and/or Unit Managers educated all licensed nurses to initiate one of these assessment tools for any resident noted with a change in condition. The tool cues every shift to assess and document on the resident noted with a change in condition for 72 hours or until the condition change had resolved. - The Unit Managers and or RN Weekend Supervisor would make daily observations of resident samples on each nursing unit to ensure the licensed nurses were completing accurate, thorough, and timely assessments of the residents; they would also validate by interview and observation that the licensed nurses were following the care plans and documenting accurate, thorough, and timely resident information. They would review all new physician orders, 72 hour alert charting tools, care plan updates, and shift reports daily until deemed necessary by the Performance Improvement Committee. The findings would be documented on the Resident Change of Condition/Assessment audit tool with the	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 72 hour alert charting tools, care plan updates, and shift reports daily until deemed unnecessary as determined by the Performance Improvement Committee. Audit findings will be documented on a Resident Change of Condition/Assessment audit (Attachment A), and the ***Unit Manager and/or Weekend Supervisor*** will date and initial the gold copy of the Physician Telephone Orders sheet. The ***Unit Managers and/or Registered Nurse Weekend Supervisor*** will also review all new physician orders for any medications with serious side effects and validate care plans updated with appropriate interventions. Any identified concerns will be corrected immediately by the ***Unit Manager*** and/or ***Registered Nurse Weekend Supervisor*** with appropriate follow-up with the licensed nurse. All audit findings will be reviewed at the weekly ***Performance Improvement Committee***. The Committee will meet weekly until substantial compliance is achieved.	

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F 282	Continued From page 8 date/initial of the physician's orders (gold copy). Any identified concerns would be corrected immediately with appropriate follow-up with the licensed nurse. - The audit findings would be reviewed weekly by the Performance Improvement Committee. ** The State Survey Agency validated the corrective action taken by the facility as follows: Verified documentation of a head to toe nursing assessment with care plan review for all in-house residents, completed on 02/18/14. Interviews with the SDC and DON, on 02/19/14 at 9:30 AM and 9:35 AM respectively, revealed nursing assessments to include head to toe skin assessments and vitals sign and review of all resident care plans were completed on all residents to ensure any change in conditions were identified and care plans were complete and accurate. Review of in-service/education records, dated 02/12/14, revealed all licensed staff was inserviced on the stop and watch early warning tool, Situation, Background, Assessment and Recommendation (SBAR) interact tool, condition change of a resident policy/procedure, 72 hour charting checklist, high alert medications, resident refusal of care policy/procedure, documentation do's and don'ts reference guide, assessment in the computer system, care path interact tools, care plans policy/procedure, and the change in condition audit tool. The 72 hour monitoring tool was verified in effect for residents with a change in condition or any	F 282		

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F 282	Continued From page 9 new order received. Verified documentation of the change in condition audit, the tool has been in effect since 02/12/14 with no concerns. Interviews with RN Unit Manager (UM), LPN UM, RN #2, LPN #1, LPN #5, LPN #6, LPN #7, LPN #8, and LPN #9 on 02/17/14 at 4:30 PM, 4:38 PM, and 4:45 PM, and on 02/18/14 at 10:15 AM, 10:25 AM, 10:30 AM, 10:45 AM and 11:00 AM respectively, revealed they were inserviced related to the SBAR, Stop and Watch, side effects, 72 hour charting tool and care plans. The RN and LPN UMs revealed they were conducting audits and reviewing physician orders, 72 hour alert charting tools, care plan updates, and shift reports daily to ensure accurate and timely resident assessments were completed by staff. Interview with the Pharmacist Consultant, on 02/18/14 at 10:55 AM, revealed he reviewed all residents medications to ensure no other resident were on chemotherapy medications. Interviews with the Executive Director (ED) and DON, on 02/18/14 at 11:20 AM and 11:30 AM respectively, revealed Performance Improvement (PI) meetings were being conducted weekly with one scheduled for 02/19/14. They stated the last time they had one was 02/12/14 and they went over the audit tools and discussed what would be monitored. They stated on 02/19/14 they would look for any trends or concerns that had been identified, and update on the education. They revealed they would continue weekly meetings until compliance was sustained. They revealed they also had daily meetings (Mon-Fri) to discuss any concerns with the audit tools. The meeting was more detailed and resident specific.	F 282		

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F 309 F 309 SS=J	Continued From page 10 483.25 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, record review, and review of the facility's Condition Change of a Resident policy, and the Hospital Office Follow-up Report, it was determined the facility failed to ensure each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the plan of care for one (1) of seven (7) sampled residents (Resident #1). The facility failed to provide ongoing assessments for Resident #1 while on Chemotherapy and after staff identified an increased temperature. Resident #1 started chemotherapy for gastric cancer on 01/16/14. The resident began having nausea, vomiting, diarrhea, and a temperature of 101.8 degrees Farenheit (F) on 01/27/14, with a new order from the resident's primary physician which included Tylenol 650 milligrams (mg) suppository every six (6) hours as needed for an increased temperature. Labwork was collected on 01/30/14 with results received on 01/31/14, indicating a low white blood cell count of 0.9	F 309 F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Resident #1 no longer resides at the facility. On February 3, 2014 the Director of Nursing conducted assessment education with the Licensed nurse who provided care for resident #1, including assessments for gastrostomy tube verification, gastric residual checks, and flushing of gastrostomy tubes. A review of the care plans for resident #1 and facility interview with the licensed nurse revealed she did follow the plan of care, but failed to document all her assessment and monitoring information. The following information has been placed with the resident record and the Licensed nurse was reeducated on her documentation skills on Feb 3, 2014. On the nightshift beginning at 2300 on January 31, 2014 at approx 11:30pm the licensed nurse entered resident #1 room and checked the resident O2 saturation with a reading of 96%. At that time resident #1 was sitting up on the side of the bed wearing a t-shirt. The licensed nurse did not check the tube feeding for placement or residual at that time, as no medications were due and the tube feeding was running at the time. At that time the LN asked the resident if resident #1 was ok and resident #1 replied yes. The resident did not complain of any nausea/vomiting/diarrhea, no abdominal cramping, no fatigue, and no complaints of pain.	02/24/14

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F 309	Continued From page 11 (normal 4.0-10.0) The resident was moved to a private room at this time on reverse isolation precautions, as a nursing intervention. The Oncologist ordered Neupogen injections, to increase the resident's white blood cell count. On 01/31/14 at 5:29 PM, the facility documented the resident's temperature of 100.5 degrees F; however, there was no documented evidence of a resident assessment or administration of medication for the increased temperature at that time. In addition, there was no documented evidence the licensed staff had conducted ongoing assessments of Resident #1 for the remainder of that shift, until 11:00 PM; and on the next shift (11-7 AM on 02/01/14). Resident #1 was found in bed deceased, on 02/01/14 at 8:00 AM, with signs of lividity, blood pooling in lowest parts of his/her body with darkening of the skin in the independent parts of the body, and rigor set in as illustrated by the fixed position of the resident's extremities. (Refer to F282) The facility's failure to ensure each resident received necessary care and services related to the failure to provide an on-going assessment of Resident #1 after a change in condition has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/11/14 and determined to exist on 01/31/14. The facility was notified of the Immediate Jeopardy on 02/11/14. An acceptable Allegation of Compliance (AoC) was received on 02/18/14 alleging the removal of Immediate Jeopardy on 02/19/14. The State Survey Agency validated, on 02/19/14, the Immediate Jeopardy was removed on 02/19/14, as alleged. The scope and severity was lowered to a "D" at 482.20 Resident Assessment, F-282 and 485.25 Quality of Care, F-309 while the	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The licensed nurse noted no shortness of air, heard no audible wheezing and noted the resident had no cough. The licensed nurse observed the resident gastrostomy tube site and assessed the dressing to be clean and dry. The licensed nurse also assessed visually the abdomen was not distended. The licensed nurse assessed the resident to have no signs or symptoms of dehydration as evidenced by observing moist lips and mouth. The licensed nurse also noted the resident's skin to be warm and supple when she palpated resident #1 hand. The licensed nurse also assessed the resident's tracheostomy to be clean and at midline. These findings were documented as completed on the Medication and Treatment Record by the licensed nurse on 2-1-14. Shortly after 11:30pm- The CNA reported to the licensed nurse obtaining a tympanic temperature of approx 98 degrees. The CNA also told the licensed nurse the resident wanted the feeding pump off due to feeling full. Due to the resident not having any complaints shortly before when the licensed nurse was in the resident room, and the licensed nurse knowing the resident had a history of	

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F 309	Continued From page 12 facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes. The findings include: Review of the Condition Change of a Resident policy, revised 10/31/06, revealed staff was to monitor and assess the resident's condition and response to interventions until stable. Record review revealed the facility admitted Resident #1 on 05/24/13 with diagnoses which included Malignant Neoplasm of the stomach, head/neck mass, Malignant Neoplasm of the mandible, Gastrostomy, and Tracheostomy. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/24/13, revealed the facility assessed the resident's cognition as cognitively intact with a Brief Interview for Mental Status (BIMS) score of "14" which indicated the resident was interviewable. The resident was a full code. Review of the Hospital's Office Follow-up Report, dated 01/16/14, revealed Resident #1 began chemotherapy for gastric carcinoma (cancer) on 01/16/14. Review of the Comprehensive Care Plan for Chemotherapy, initiated 07/17/13, revealed an intervention for nurses to monitor the resident for an increased temperature, signs/symptoms of infection, nausea, vomiting, diarrhea, and abdominal cramping and signs/symptoms of dehydration while having chemotherapy. Review of the Nurse's Notes, dated 01/27/14, revealed the resident complained of nausea, vomiting, and diarrhea with a temperature of	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* dictating when the pump was on/off and the resident being known at times to just turn it off by self, this did not cause concern for the licensed nurse. At approx 3:30am- the licensed nurse entered the resident #1 room and noted the resident to be turned facing the window with arms up under the pillow. The resident appeared to be sleeping. The licensed nurse turned the tube feeding pump on at that time. The licensed nurse did not want to disturb the resident because she knew the resident was ill and needed rest so therefore she did not turn on the light or arouse resident #1. On February 12, 2014, the Director of Nursing Services and the Consultant Pharmacist audited all in-house residents for physician orders for any other residents receiving chemotherapeutic agents to validate evidence of accurate, thorough and timely documentation of clinical assessments and monitoring for medication side effects. No other residents were receiving any chemotherapeutic agents. On February 12, 2014, Nursing Administration to consist of ***Director of Nursing Services, Unit Managers, Minimum Data Set Coordinators,***	

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F 309	Continued From page 13 101.8 degrees F. An order was received for phenergan (antiemetic) 12.5 milligrams (mg) suppository every four hours as needed for nausea/vomiting, and Tylenol (fever reducer) 650 mg suppository every six hours as needed for increased temperature. Review of the Laboratory Report, received 01/31/14, revealed a white blood cell count of 0.9 (normal 4.0-10.0). Review of the Nurse's Notes, dated 01/31/14 at 2:27 PM and 4:59 PM, revealed Resident #1 was moved to a private room in reverse isolation for a low white blood cell count. Review of the Weights and Vital Signs Summary, dated 01/31/14 at 5:29 PM, revealed a temperature of 100.5 degrees F orally (normal 97.3-98.7 orally); however, review of the Nurse's Notes for 01/31/14 and the January 2014 Medication Administration Record (MAR) revealed no documented evidence the resident was assessed by licensed staff and/or medication was administered for the temperature. In addition, further review revealed no documented evidence ongoing assessments were conducted for Resident #1 from the time the temperature was identified on 01/31/14 at 5:29 PM until the resident was found deceased in bed on 02/01/14 at 8:00 AM. Interview with Licensed Practical Nurse (LPN) #5, on 02/11/14 at 3:00 PM, revealed he was the 3 PM-11 PM shift nurse, on 01/31/14. He stated he was aware the resident had a temperature of 100.5 degrees; however, the resident refused a Tylenol suppository. He stated he was supposed to document the refusal on the back of the MAR; however, review of the MAR, dated January 2014, revealed no evidence of the refusal.	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ***Registered Nurses and Licensed Practical Nurses*** audited all in-house resident care plan interventions related to chemotherapeutic medications to ensure the interventions are appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. Any medication intervention identified as not having been implemented was implemented immediately. No other residents have a chemotherapeutic care plan. On February 18, 2014, all current residents were assessed head to toe by the ***Director of Nursing, Unit Managers, Case Management, Staff Development Coordinator and a RN***. All current resident care plans were reviewed to ensure that the interventions are appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. On February 10, 2014, the ***Registered Nurse Staff Development Coordinator and/or the Director of Nursing Services, and/or Unit Managers***, initiated education with all Licensed Nurses related to use of the SBAR/ Interact program for identification of resident changes in condition. The assessment and care plan education consisted of:	

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F 309	Continued From page 14 Interview with Certified Nurse Aide (CNA) #8, on 02/11/14 at 1:55 PM, revealed she worked on 01/31/14 from 11:00 PM to 7:00 AM. She stated she obtained the resident's temperature at the beginning of the shift; however, she could not remember the results. She stated the resident had complained his/her stomach was hurting and wanted his/her feeding shut off. She stated she told LPN #1. She stated she checked on the resident several times and he/she was still in bed and she thought the resident was asleep. She stated it was dark and the lights were off. Interview with LPN #1, on 02/06/14 at 2:40 PM and on 02/10/14 at 10:50 AM, revealed she was the nurse on 01/31/14 from 11:00 PM to 7:00 AM. She stated the resident was visualized at the beginning of her shift and had an oxygen saturation of 96 percent (%). She asked the resident how he/she was feeling and the resident responded "the same". She told the resident to use the call light if he/she needed assistance. She stated the aide reported to her that the resident wanted his/her feeding tube turned off. She stated she went to the room approximately ten (10) minutes after the aide told her. The LPN stated the resident had his/her back to her and was in the fetal position. She stated she did not bother him/her, just noted that the pump was turned off and it was still hooked to the resident. She stated she should have assessed the resident and talked to the resident about why the pump was turned off. The LPN revealed she went back in between 3-3:30 AM to turn the pump back on, but did not assess the resident at the time. She stated the resident was in the same position. Review of the Nurse's Note, dated 02/01/14 at	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* • Interact III Critical Pathways • use of shift reports to communicate resident status • follow up assessment and monitoring of residents with a change in condition using an alert charting system • PRO 61003-01 Condition Change of a Resident • TL 6103-09 Reporting Change in Condition to the Physician Education will be ongoing until all licensed nurses have attended. Any licensed nurse that has not received the education by February 13, 2014 will not be allowed to work until receiving the education. On February 12, 2014 the ***Registered Nurse Staff Development Coordinator and/or Director of Nursing Services, and/or Unit Managers*** initiated additional assessment and care plan education with all Licensed Nurses related to: • Use of the Omnicare Pharmacy website to look up medication side effects • observing for side effects of medications	

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F 309	Continued From page 15 8:00 AM, revealed Resident #1 was found with no respirations, pulse, heartbeat and no blood pressure. No Cardiopulmonary Resuscitation was started due to signs of lividity, blood pooling in the lowest parts of body with darkening of the skin in the independent parts of the body, and rigor set in as illustrated by the fixed position of the resident's extremities. Interview with LPN #2, on 02/17/14 at 9:32 AM, revealed she came on shift around 6:45 AM on 02/01/14, and received report from LPN #1 about 7:15 AM. The LPN stated LPN #1 told her Resident #1's feeding tube was turned off around 2:00 AM because his/her stomach was "aching." LPN #2 revealed she entered Resident #1's room at 8:00 AM, and knew immediately that the resident was deceased. She revealed the resident was laying on his/her right side facing the door. The resident had no pulse, blood pressure, was not breathing, and had no heartbeat, and the resident was extremely cold and stiff. Interview with the resident's Oncologist, on 02/11/14 at 4:40 PM, revealed he would have expected vital signs every shift with routine monitoring of Resident #1, per the facility's change in condition policy. Interview with the Director of Nursing (DON), on 02/11/14 at 3:50 PM, revealed the resident was in reverse isolation precautions as a nursing intervention. She stated she expected nursing to document an assessment every shift on Resident #1 as he/she was having side effects from the chemotherapy treatment. She revealed an assessment should have included skin color, warmth, respirations, and abdominal distention. She revealed there was no specific facility policy	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* • updating resident care plans with serious side effects for high risk medications • reporting to the physician serious medication side effects On February 12, 2014 the Director of Nursing Services also implemented a 72 hour Alert Charting tool as a guide to document evidence of resident assessment and following the care plan. The ***Registered Nurse Staff Development Coordinator and/or Director of Nursing Services, and/or Unit Managers*** educated all licensed nurses to initiate one of these assessment tools for any resident noted with a change in condition. The tool cues every shift to assess and document on the residents noted with a change in condition for 72 hours or until the condition change is resolved. The ***Unit Managers and/or Registered Nurse Weekend Supervisor*** will make daily observations of resident samples on each nursing unit to ensure Licensed nurses are completing accurate, thorough and timely assessments of the residents; they will also validate by interview and observations that the licensed nurses are following the care plans and documenting accurate, thorough and timely resident information. Unit Managers and/or Registered Nurse Weekend Supervisor review all new physician orders,	

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F 309	Continued From page 16 related to nursing assessments. The facility implemented the following actions to remove the Immediate Jeopardy: - On 02/18/14, all current residents were assessed head to to by the DON, Unit Managers, Case Management, Staff Development Coordinator, and a Registered Nurse. All current resident care plans were reviewed to ensure the interventions were appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. - On 02/03/14, the DON conducted assessment education with LPN #1, who provided care for Resident #1, including assessments for gastrostomy tube verification, gastric residual checks, flushing gastrostomy tubes, and documentation skills. - On 02/10/14, the RN Staff Development Coordinator and/or the DON and/or Unit Managers initiated education with all Licensed Nurses related to the use of Situation, Background, Assessment and Recommendation (SBAR)/interact program for identification of resident changes in condition. The assessment and care plan education consisted of the use of Interact III Critical Pathways, use of shift reports to communicate resident status, follow up assessment and monitoring of residents with a change of condition using an alert charting system. Education would be ongoing until all licensed nurses have attended. Any licensed nurse that had not received the education by 02/13/14, would not be allowed to work until receiving the education.	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 72 hour alert charting tools, care plan updates, and shift reports daily until deemed unnecessary as determined by the Performance Improvement Committee. Audit findings will be documented on a Resident Change of Condition/Assessment audit (Attachment A), and the ***Unit Manager and/or Weekend Supervisor*** will date and initial the gold copy of the Physician Telephone Orders sheet. The ***Unit Managers and/or Registered Nurse Weekend Supervisor*** will also review all new physician orders for any medications with serious side effects and validate care plans updated with appropriate interventions. Any identified concerns will be corrected immediately by the ***Unit Manager*** and/or ***Registered Nurse Weekend Supervisor*** with appropriate follow-up with the licensed nurse. All audit findings will be reviewed at the weekly ***Performance Improvement Committee***. The Committee will meet weekly until substantial compliance is achieved.	

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F 309	Continued From page 18	F 309		

thorough, and timely assessments of the residents; they would also validate by interview and observation that the licensed nurses were following the care plans and documenting accurate, thorough, and timely resident information. They would review all new physician orders, 72 hour alert charting tools, care plan updates, and shift reports daily until deemed necessary by the Performance Improvement Committee. The findings would be documented on the Resident Change of Condition/Assessment audit tool with the date/initial of the physician's orders (gold copy). Any identified concerns would be corrected immediately with appropriate follow-up with the licensed nurse.

- The audit findings would be reviewed weekly by the Performance Improvement Committee.

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

Verified documentation of a head to toe nursing assessment with care plan review for all in-house residents, completed on 02/18/14. Interviews with the SDC and DON, on 02/19/14 at 9:30 AM and 9:35 AM respectively, revealed nursing assessments to include head to toe skin assessments and vitals sign and review of all resident care plans were completed on all residents to ensure any change in conditions were identified and care plans were complete and accurate.

Interview with LPN #1 revealed she received the assessment education related to gastrostomy tubes, resident change in condition, updating care

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F 309	Continued From page 19 plans, 72 hour alert charting, and documentation skills. Review of in-service/education records, dated 02/12/14, revealed all licensed staff was inserviced on the stop and watch early warning tool, SBAR interact tool, condition change of a resident policy/procedure, 72 hour charting checklist, high alert medications, resident refusal of care policy/procedure, documentation do's and don'ts reference guide, assessment in the computer system, care path interact tools, care plans policy/procedure, and the change in condition audit tool. Verified documentation of an audit of medications for in-house residents on 02/12/14 and no residents were currently taking chemotherapy agents. Verified the audit per interview with the consultant pharmacist. 72 hour monitoring tool-- verified in effect for residents with a change in condition or any new order received. Verified documentation of the change in condition audit, the tool has been in effect since 02/12/14 with no concerns. Interviews with RN Unit Manager (UM), LPN UM, RN #2, LPN #1, LPN #5, LPN #6, LPN #7, LPN #8, and LPN #9 on 02/17/14 at 4:30 PM, 4:38 PM, and 4:45 PM, and on 02/18/14 at 10:15 AM, 10:25 AM, 10:30 AM, 10:45 AM and 11:00 AM respectively, revealed they were inserviced related to the SBAR, Stop and Watch, side effects, 72 hour charting tool and care plans. The RN and LPN UMs revealed they were conducting audits and reviewing physician orders, 72 hour alert charting tools, care plan updates, and shift reports daily to ensure accurate and timely	F 309		

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F 322	Continued From page 21 metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedures, it was determined the facility failed to ensure a resident who was fed by gastrostomy tube received the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities for one (1) of seven (7) sampled residents (Resident #1). The findings include: Review of the facility's Tube Placement Verification and Gastric Residual Volume (GRV) policy/procedure, released 04/28/13, revealed GRV was checked in enterally fed patients to protect against aspiration pneumonia and to monitor tolerance of enteral feeding and gastric emptying. The placement of the gastric tube was checked by aspiration to validate that the tube was in the stomach. The frequency of placement verification and GRV was before each feeding and/or flush via syringe, and every 6-8 hours for a gastrostomy tube depending on the patient's tolerance of feeding. Review of the Flushing Feeding Tube policy/procedure, revised 04/28/11, revealed the feeding tube was flushed before initiating a pump	F 322	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Resident #1 no longer resides in the center. All current residents with tube feedings were reviewed by the Director of Nursing or Unit Manager 02/10/14 to validate physician orders in place regarding checking placement of the tube before each feeding and/or flush via syringe, and every 6-8 hours for a gastrostomy tube depending on the patient's tolerance to feeding. This review also included validating tolerance to the ordered tube feeding. Any concerns were addressed with physician and Registered Dietician notification. License Nurse #1 was educated on tube feeding verification by the DNS on 02/03/14 prior to OIG coming to facility. License Nurse #1 did not check for residual at the start of her shift, as no medications were due at that time. All Licensed Nurses were educated by the Staff Development Coordinator RN on PRO 66006 Tube Placement Verification and Gastric Residual Volume beginning on 02/10/14 and concluding on 02/19/14. Education will be ongoing until all licensed nurses have attended. Any licensed nurse that has not received the education by 02/24/14 will not be allowed to work until receiving the education. Any newly hired nurses will receive this training as part of General Orientation.	02/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185142	A. BUILDING _____ B. WING _____	C 02/19/2014

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F 322	Continued From page 23 and 11:45 PM. She revealed it was not uncommon for the resident to turn off his/her enteral feeding as his/her stomach felt "full." LPN #1 stated she went into the resident's room approximately ten (10) minutes later, and the enteral feeding was off. She stated she did not speak to the resident as his/her back was turned away from her and she did not conduct an assessment of the resident at that time. She revealed between 3:00 AM and 3:30 AM, she went back into the room and turned the resident's enteral feeding on. She did not flush the feeding tube, check placement, residual, or assess the resident prior to the initiation of the feeding. Interview with the Primary Physician, on 02/07/14 at 9:50 AM and on 02/11/14 at 9:45 AM, revealed he was not specifically aware of the resident having his enteral feeding turned off due to stomach issues. He revealed it would not be uncommon as the resident was receiving a high rate of feeding. He expected the nursing staff to check the residual and hold the feeding, if necessary. He expected staff to follow the orders per the facility protocol. Interview with the Oncologist, on 02/11/14 at 11:10 AM, revealed the resident was receiving chemotherapy for a gastric mass. He indicated the mass could cause "fullness" when the enteral feeding was initiated. He indicated if he had been made aware of the problem, he would possibly have decreased the rate of enteral feeding. Interview with the Registered Dietician, on 02/11/14 at 10:00 AM, revealed she was not aware of the resident having issues with his/her enteral feeding at night. She would expect staff to notify her as she would have assessed the	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 322	Continued From page 24 resident for further problems. Interview with the Director of Nursing (DON), on 02/11/14 at 10:15 AM, revealed she expected staff to follow the physician's orders related to placement and residual of enteral feeding.	F 322		