

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

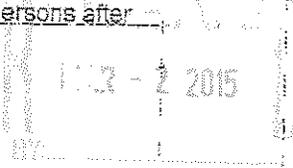
PRINTED: 02/13/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000  F 280 SS=D	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 01/27/15 and concluded on 01/30/15. Deficiencies were cited with the highest Scope and Severity of an "E".</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for three (3) of ten (10) sampled residents (Resident #2, #3 and #5).</p>	F 000  F 280	<p>Bracken County Nursing and Rehabilitation does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or other legal proceedings. This allegation of compliance is not intended to and does not establish any standard of care, contract obligation, or position, and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this allegation of compliance should be considered or relied upon as a waiver of any potentially applicable Peer Review, Quality Assurance, self critical examination, or any other legal privilege which the Facility may have. The Facility does not waive and specifically reserves the right to assert these privileges in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance, and plan of correction as part</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Cary McRobb</i>	TITLE  RN DON	(X6) DATE  2/23/15
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

No. 2974 P. 3

Mar. 2, 2015 5:08PM

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F 280	<p>Continued From page 1</p> <p>Resident #3's Comprehensive Care Plan was not revised after the resident was diagnosed and treated for a Fecal Impaction at the hospital Emergency Room (ER) on 07/13/14.</p> <p>Resident #2's Care Plan was not revised when the resident's scoop mattress was removed from the bed.</p> <p>Resident #6's Care Plan was not revised to include changes in the dose of his/her Dilantin (anti-seizure medication), and for the laboratory (lab) monitoring of the Dilantin levels.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans-Comprehensive", revised October 2010, revealed care plans were revised as information about the resident and the resident's condition changed. Review of the Policy revealed the care planning/interdisciplinary team was responsible for the review and revising of care plans when there was a significant change in a resident's condition, and when the desired outcome was not met.</p> <p>1. Review of Resident #3's medical record revealed the facility admitted the resident on 04/17/07, with diagnoses which included Non-Alzheimer's Dementia and Failure to Thrive. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/10/14, revealed the facility assessed Resident #3 as having both short and long term memory loss, as requiring total dependence of two (2) staff for toileting, and as always incontinent of bowel and bladder.</p>	F 280	<p>of its ongoing efforts to provide quality of care to residents.</p> <p>F280</p> <p>1. The Director of Nursing and the MDS Coordinator reviewed 483.20(d)(3), 483.10(k)(2) regarding Residents rights to participate in care planning and revisions to care plans. On 1/30/15, the Director of Nursing and MDS Coordinator reviewed and revised Resident #3's Comprehensive Care Plan to reflect interventions in place and documented to ensure fecal impaction does not reoccur and to ensure areas of all aspects of care were accurately addressed in the care plan. This included noting a problem area of a history of fecal impaction and constipation for Resident #3 with interventions including revision of the bowel protocol, review of bowel movements including consistency and size. On 1/30/15, the Director of Nursing and the MDS Coordinator reviewed and revised Resident #2's comprehensive care plan to reflect interventions in place and documented to ensure the interventions were appropriate and accurately reflect the current physical and mental status of Resident #2 and physician orders. The physician was notified and the scoop</p>	2/24/15
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F 280	<p>Continued From page 2</p> <p>Review of the Comprehensive Care Plan dated 10/17/13, revealed a care plan for the resident's risk for bowel elimination problems related to decreased mobility, side effects of medication, Alzheimer's Disease, and decreased liquid intake. Continued review of the care plan revealed the goal stated Resident #3 would have a regular bowel movement (BM) pattern as evidenced by soft/formed stool at least every three (3) days. Further review revealed several interventions which included: monitor BM status; report changes in BM status to Physician; and administer bowel regimen as per Physician's Orders.</p> <p>Review of the Nurse's Note dated 07/13/14 at 2:00 AM, revealed Resident #3 had several loose stools that night and was moaning when having the stools. Review of the Nurse's Note entry on 07/13/14 at 2:50 AM, revealed the nurse was called to the room by the Certified Nursing Assistant (CNA). Per the Note Resident #3 was noted to be ashen and clammy, with a blood pressure of 125/97, pulse of 89 and respirations of 20. Review of the Nurse's Notes on 07/13/14 at 3:00 AM and 3:30 AM, revealed the Physician was notified and Resident #3 was transported to the hospital ER where he/she was diagnosed with a Fecal Impaction (a large lump of dry, hard stool that stays stuck in the rectum caused from being constipated).</p> <p>Review of the Hospital Discharge Instructions dated 07/13/14, revealed Resident #3 was diagnosed with a Fecal Impaction and a UTI and received x-rays, laboratory (lab) tests, cardiac monitoring and was given a Fleets Enema.</p> <p>However, additional review of Resident #3's</p>	F 280	<p>mattress was immediately removed from the physician orders and the care plan. On 1/30/15, the Director of Nursing and the MDS Coordinator reviewed and revised Resident #6's Comprehensive Care Plan to ensure all aspects of care were accurately and appropriately care planned, including revisions to the seizure care plan to include changes in Dilantin dosages, monitoring of Dilantin levels, and the potential Dilantin interaction with alcohol.</p> <p>2. On 2/23/15, 100% of all residents Comprehensive Care Plans were reviewed by the Director of Nursing and the MDS Coordinator for accuracy and revisions were made as indicated, to ensure each individual care plan reflected each resident's current physical and mental status with appropriate interventions documented.</p> <p>3. On 1/30/15, the Director of Nursing educated the MDS Coordinator regarding the Comprehensive Assessment and Care Planning for each resident, to ensure all residents have a care plan with appropriate interventions for all aspects of each resident's care. On 1/30/15, all staff were educated by the Staff Development Coordinator that any change in a resident's</p>	
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No. 2374 P. 5

Mar. 2. 2015 5:09PM

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F 280	<p>Continued From page 3</p> <p>Comprehensive Care Plan, dated 10/17/13, revealed no documented evidence the care plan was revised in regards to Resident #3's diagnosis of Fecal impaction after the facility re-admitted the resident, to include interventions to decrease the risk for further Fecal Impactions. Although the Care Plan had an area to check if a resident had a history of Fecal Impaction, this was not checked to indicate Resident #3 had a history of Fecal Impaction in regards to the 07/13/14 ER visit.</p> <p>Interview, on 01/29/15 at 5:20 PM, with MDS Coordinator #1, revealed she revised care plans with any new Physician's Orders. She stated she attended the morning clinical meetings and received information related to which residents went to the ER, but did not always follow up with checking the diagnoses when the resident returned to the facility. However, she stated she always reviewed the chart during the MDS Assessment timeframes and should have caught the diagnoses, including Fecal Impaction to add to Resident #3's Care Plan when she completed the 12/10/14 MDS.</p>	F 280	<p>room must be coordinated with the Charge Nurse, Director of Nursing, and/or the Assistant Director of Nursing to ensure the physician is notified, orders obtained as needed, and care plan is updated.</p> <p>4. The MDS Coordinator/Director of Nursing will audit 20% of care plans weekly X one month, then monthly X 2 months to ensure Comprehensive Care Plans are accurate and reflect appropriate interventions. Care plans will be revised immediately as needed. The results of these audits will be reported to the Quality Assurance Committee for review and addressed immediately as needed.</p>	
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	<p>Interview, on 01/30/15 at 5:35 PM, with the Director of Nursing (DON) revealed the MDS Nurses revised residents' Comprehensive Care Plans. Per interview, the MDS Nurses got the information for the care plan updates in the morning meetings held Monday through Friday. She stated the Interdisciplinary Team talked about who had went to the ER the following day, and the MDS Nurses were to follow through with updating the care plans as needed. She stated Resident #3's care plan should have been revised to indicate the resident had a history of Fecal Impaction because he/she needed to be followed</p>			
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F 280	<p>Continued From page 4 more closely related to his/her BMs.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted him/her on 05/21/13, with diagnoses which included Dementia with Behavioral Disturbance and Depression. Review of the Quarterly MDS Assessment dated 11/13/14, revealed the facility assessed Resident #2 as having a Brief Interview for Mental Status (BIMS) of a thirteen (13) out of fifteen (15), indicating he/she was cognitively intact. Further review of the MDS revealed the facility assessed Resident #2 as having no falls.</p> <p>Review of Resident #2's Comprehensive Care Plan dated 02/24/14, revealed the facility had care planned the resident for the potential for falls related injury due to weakness, cognitive concerns, hearing loss, visual changes, inability to transfer without a mechanical lift. Continued review of the falls care plan revealed the goal stated Resident #2 would not sustain a fall related injury. Further review of the falls care plan revealed several interventions listed which included: total assist with transfers with a mechanical lift; bed in lowest position; and a scoop mattress.</p> <p>Review of the Physician's Orders dated January 2015, revealed orders for a scoop mattress to the bed for fall prevention. Review of the Treatment Administration Record (TAR) dated January 2015 revealed a treatment procedure for a scoop mattress to the bed as a fall prevention. Continued review of the January 2015 TAR revealed nurses had initiated from 01/01/15 through 01/27/15, the scoop mattress as a fall prevention, indicating the scoop mattress was in place to the resident's bed.</p>	F 280		
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5259 ASBURY ROAD AUGUSTA, KY 41002		
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F 280	Continued From page 5  However, observation of Resident #2 on 01/27/15 at 4:05 PM, revealed the resident was lying on his/her back on the bed with the two (2) upper half siderails raised, and eyes closed with no scoop mattress observed on the bed. Observation of Resident #2 on 01/28/15 at 9:00 AM, revealed the resident was in the bed tilted to the left with the two (2) upper half siderails raised and eyes closed, and no scoop mattress observed.  Observation of Resident #2 on 01/29/15 at 2:10 PM with CNA #1, revealed there was no scoop mattress on the resident's bed. CNA #1 stated she was assigned to Resident #2, and she referred to her Nurse Aide Care Plan for interventions the resident needed. She reviewed her Nurse Aide Care Plan and stated there was no intervention for Resident #2 to have a scoop mattress on his/her bed.  Interview with Registered Nurse (RN) #2 on 01/29/15 at 2:15 PM, revealed she was the Charge Nurse assigned to Resident #2 and she signed the residents' treatments on the TART. RN #2 checked Resident #2's bed during the interview, and stated she thought the mattress was a scoop mattress because the edges of the mattress were firm.  Interview and observation of Resident #2's bed with the Assistant Director of Nursing (ADON) on 01/29/15 at 2:40 PM, revealed Resident #2 did not have a scoop mattress on his/her bed. She stated Resident #2 no longer had the scoop mattress because he/she did not try to get up out of the bed anymore, and the scoop mattress did not fit the resident's long bed frame. She stated	F 280			

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F 280	<p>Continued From page 6</p> <p>Resident #2 had not had the scoop mattress for a long time and the order for the scoop mattress needed to be discontinued. Per interview, Resident #2's care plan needed to be revised as Resident #2 no longer needed the scoop mattress.</p> <p>Interview with MDS Nurse #1 on 01/29/15 at 5:20 PM, revealed she revised residents' care plans. Per interview, if Resident #2 had the scoop mattress removed from his/her bed, she should have been notified so she could revise the resident's care plan. MDS Nurse #1 stated the nurse assigned to the resident at the time the mattress was removed could also have revised the care plan.</p> <p>Interview with the DON on 01/30/15 at 5:35 PM, revealed Resident #2's scoop mattress was too short for the bed and the facility had ordered a new mattress. She stated the scoop mattress was an intervention the staff had placed after a fall; however, the resident no longer attempted to get out of bed. Per interview, the Physician should have been notified for an order change and the nurse assigned to the resident when the scoop mattress was removed should have updated his/her care plan. Continued interview revealed the nurses were fairly new right now and were growing, and she had to guide the nurses as it was a work in progress.</p> <p>3. Record review revealed the facility admitted Resident #6 on 11/08/14, with diagnoses which included a History of Seizures Secondary to Alcohol Abuse, Metabolic Encephalopathy Secondary to Alcohol Withdrawal and Alcohol Liver Disease. Review of the Admission Minimum Data Set (MDS) Assessment, dated</p>	F 280		
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F 280	<p>Continued From page 7</p> <p>????, revealed the assessed Resident #6 as having a diagnosis of Seizure Disorder. Review of Resident #6's Comprehensive Care Plan, dated, revealed the facility care planned the resident for the diagnosis of Seizure Disorder with interventions which included ?????.</p> <p>Review of Resident #5's Admission Physician's Orders, dated 11/09/14, revealed orders which included Dilantin 400 milligram (mg) once a day. Review of the Telephone Physician's Order dated 11/11/14 at 5:30 PM, revealed Registered Nurse (RN) #3 received an order to increase Resident #6's Dilantin medication to 400 mg by mouth in the AM (morning) and 200 mg by mouth at bedtime, and to obtain a laboratory (lab) level for the Dilantin on 11/21/14. However, further review of Resident #6's care plan revealed no documented evidence it was updated and revised to include the the increase in the resident's Dilantin, the lab order for the Dilantin level and for further lab monitoring of his/her Dilantin levels.</p> <p>Interview, on 01/29/15 at 5:40 PM, with RN #3 revealed she did remember there was something to do with Resident #6's Dilantin levels in November 2014. Per interview, she thought Resident #6's levels were low. RN #3 stated she did not know why she didn't update Resident #6's care plan with the orders she received.</p> <p>Interview, on 01/29/15 at 5:50 PM and 01/30/15 at 5:30 PM, with the Director of Nursing (DON) revealed "somenow" the lab order had been missed and was not available for review in the "management meeting" held each morning where all new orders were reviewed. Per interview, Resident #6's care plan should have been updated and revised regarding the order to</p>	F 280		
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F 280 Continued From page 8  
increase the Dilantin, and for monitoring the Dilantin Levels and the potential Dilantin interaction with alcohol.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 280

F 282 F282

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 facility's policy, it was determined the facility failed to ensure services were provided in accordance with each resident's written Comprehensive Care Plan for (4) of ten (10) sampled residents (Residents #3, #4, #5 and #7).

Resident #3's Comprehensive Care Plan stated the resident was at risk for bowel elimination problems with interventions which included monitoring bowel movements (BMs) and administering and monitoring the effectiveness of medications used for bowel elimination. Record review revealed there was no documented evidence Resident #3 had a bowel movement (BM) from 07/09/14 until 07/13/14, four (4) days later. On 07/13/14, Resident #3 was noted to have several loose stools, became ashen and clammy, and was sent to the hospital Emergency Room (ER) where he/she was diagnosed with a Fecal Impaction and a Urinary Tract Infection (UTI).

In addition, there was no documented evidence

1. The Director of Nursing has reviewed 483.20 (k)(3)(ii), services by qualified persons/Per care plan. The facility will provide services by qualified persons in accordance with each resident's written plan of care. On 1/30/15, the physician was notified of the inconsistent bowel patterns of Residents #3, #4, #5, and #7. The current physician orders and care plan were reviewed with the physician on 1/30/15 on Residents #3, #4, #5, and #7. An abdominal/bowel assessment was by the Assistant Director of Nursing on 1/30/15 on Residents #3, #4, #5, and #7. No concerns were identified on any of the residents that were assessed, regular bowel movements had occurred within the past 48 hours, and the abdomen was soft with positive bowel sounds on Residents #3, #4, #5, and #7. The licensed nurses were educated by the Staff Development Coordinator on 1/30/15 in regards to following each resident's physician orders and individualized plan of care.

2/24/15

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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5266 ASBURY ROAD AUGUSTA, KY 41002		
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F 282	<p>Continued From page 9</p> <p>Residents #4, #5, and #7's Comprehensive Care Plans were implemented related to monitoring BMs. There was no documented evidence these residents experienced BMs for periods ranging from four (4) to five (5) days (Refer to F-309).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans-Comprehensive", revised October 2010, revealed the Comprehensive Care Plan was designed to incorporate identified problem areas and risk factors associated with problem areas. Continued review of the Policy revealed the Comprehensive Care Plan was to aid in preventing or reducing declines in residents' functional status and functional levels; it was to enhance optimal functioning of the resident, and, reflect currently recognized standards of practice for problem areas and conditions.</p> <p>1. Record review revealed the facility admitted Resident #3 on 04/17/07, with diagnoses which included <u>Failure to Thrive, Non-Alzheimer's Dementia/Osteoporosis and Atrial Fibrillation</u>. Review of the 12/10/14, Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #3 to have short and long term memory loss. Further review of the MDS revealed the facility assessed Resident #3 to always be incontinent of bowel and bladder, and to require total dependence of two (2) staff for toileting.</p> <p>Review of Resident #3's Comprehensive Care Plan dated 10/17/13, revealed a care plan related to the resident being at risk for a bowel elimination problem related to decreased liquid</p>	F 282	<p>2. On 2/20/15, the Director of Nursing/Assistant Director of Nursing completed an audit on all residents' bowel elimination records, physician orders, and care plans for individualized interventions, notified the attending physician, and new orders obtained as appropriate. On 2/20/15, the Director of Nursing/Assistant Director of Nursing reviewed and revised the Bowel Policy and Procedure to allow for a more individualized plan of care with interventions specific to each resident. The facility will monitor and track all residents on a daily basis to determine the need for dietary and/or chemical intervention to treat chronic and/or acute episodes of constipation. The Medical Director approved the revised Bowel Policy and Procedure on 2/20/15. Each resident will be reviewed as needed for the need to changes in their routine bowel elimination medications.</p>		

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F 282	<p>Continued From page 10</p> <p>intake, side effects of medication, decreased mobility and Alzheimer's Disease. Review of the care plan revealed a goal for Resident #3 to have regular BMs as evidenced by soft-formed BMs at least every three (3) days. Further review of the care plan revealed interventions which included administering the bowel regimen as per Physician's Orders, reporting changes in BM status to the Physician and monitoring the resident's BM status.</p> <p>Review of the Physician's Orders dated July 2014, revealed orders for: Nutrisource Fiber Powder (a fiber supplement) two (2) teaspoons mixed well in liquid by mouth daily; Senna Laxative (a laxative medication) 8.6 milligrams (mgs) by mouth daily; Milk of Magnesia (MOM) (a laxative medication) if no BM by the morning of day three (3), give 30 milliliters (mls) as needed; Bisac-Evac (a stimulant laxative) 10 mg suppository rectally if no BM by evening of day three (3); and an Enema rectally as needed if no BM in the morning (AM) of day four (4), then call the Physician.</p> <p>Review of Resident #3's "Elimination Report" from 06/01/14 to 07/31/14, revealed Resident #3 had a medium soft BM on 07/09/14 which was documented at 12:28 AM. However, further review of the Elimination Report revealed no documented evidence Resident #3 had another BM until 7/13/14, four (4) days later, when documentation revealed the resident had a large loose BM at 12:02 AM.</p> <p>However, there was no documented evidence Resident #3's care plan intervention to administer his/her bowel regimen as per Physician's Orders was followed. Review of the Medication</p>	F 282	<p>3. On 2/20/15, the Staff Development Coordinator educated all licensed nurses on the newly revised Bowel Policy and Procedure and provided a copy of the Medical Director approved revised Bowel Policy. All licensed nurses will follow the revised Bowel Policy and Procedure and will adhere to the Comprehensive Plan of Care for each resident.</p> <p>4. The DON/designee will monitor 100% of residents' bowel movements twice daily 5 days a week X one month, then 2 times a day X 2 months, including size and consistency of the bowel movements, to ensure each resident has a bowel movement occurring at least every 3 days per policy, and to ensure the newly revised Bowel Policy and Procedure and individualized Plan of Care is being followed. The DON/designee will review each resident's individual bowel elimination record during the morning clinical meeting to review each resident's last documented bowel movement, including size and consistency. The DON /designee will communicate the findings with medication nurse and the charge nurse for review and comparison of their bowel elimination exception report. The DON/designee will follow up with the medication nurse at the</p>		

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F 282	Continued From page 11 Administration Record (MAR) dated July 2014, revealed Resident #3 had received MOM on 07/11/14 at 4:35 PM, which was documented as "no effect", but there was no documented evidence the resident received the MOM as ordered in the AM of day three (3) without a BM, 07/12/14. Further review of the MAR revealed no documented evidence the resident received the Bisac-Evac suppository rectally if he/she had no BM by the evening of day three (3), 07/12/14.  Review of the Nurse's Notes from 07/11/14 through 07/13/14, revealed no documented evidence an abdominal/bowel assessment was completed by the nurses, even though there was no documented BM for Resident #3 on day three (3), 07/12/14. Review of the Nurse's Notes 07/13/14 revealed the nurses documented: at 2:00 AM Resident #3 had several loose stools that night, and moaned when having the stools; at 2:50 AM, the nurse was called to the room by the Certified Nursing Assistant (CNA) with the resident noted to be clammy, ashen, with vital signs listed; and at 3:00 AM and 3:30 AM the Physician was notified with orders received to transport Resident #3 to the ER, which was done. Further review of the Nurse's Notes revealed no documented evidence the nurse on 07/13/14 performed an abdominal/bowel assessment when Resident #3 was moaning with loose stools.  Review of the Hospital Discharge Instructions dated 07/13/14, revealed Resident #3 was diagnosed with a Fecal Impaction and a Urinary Tract Infection (UTI), had numerous testing performed and had received a "Fleets" Enema. Further record review revealed Resident #3 was re-admitted to the facility on 07/13/14 from the ER.	F 282	end of his/her shift to ensure the Bowel Policy and Procedure/Care Plan was followed, and determine if any call to the attending physician is needed. The DON/designee will review the Medication Administration records daily 5 times a week ongoing to ensure the Bowel Policy, Care Plan, and Physician Orders are being followed. The results of these audits will be reviewed in the daily clinical meeting by the Interdisciplinary Team. The results will also be reported to the Quality Assurance Committee for review and any concerns addressed immediately.		

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F 282	<p>Continued From page 12</p> <p>Interview, on 01/29/15 at 12:00 PM, with Registered Nurse (RN) #1, revealed she was assigned to Resident #3 for the day shift on 07/11/14 and 07/12/14. She explained, each morning the Charge Nurse printed out a bowel list of residents who had not had a BM on day three (3) and day four (4). Per interview, she was administering medications on 07/11/14 and had given Resident #3 the MOM at 4:35 PM, but there was no documentation of an abdominal/bowel assessment, so she was not sure why she gave the medication since that was just day two (2) of no BM. Continued interview revealed she should have given the MOM on 07/12/14 which would have been day three (3) without a BM, as per the order and care plan. RN #1 stated, she went around each morning and asked the CNA's if the residents on the bowel list had a BM or not, and if the resident had a BM which was not yet documented that morning, she would not give the laxative. She further stated she did not do abdominal assessments before giving pm (as needed) laxatives, but just gave the medications per orders and protocol.</p>	F 282		
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	<p>Interview, on 01/28/15 at 5:44 PM, with Licensed Practical Nurse (LPN) #2 revealed she was assigned to Resident #3 on 07/12/14 from 7:00 PM through the next morning at 7:00 AM. She stated, according to the Physician's Orders, the resident should have received a dulcolax suppository on the evening of day three (3) without a BM which would have been 07/12/14. However, she revealed according to the MAR for that date, the medication was not administered as ordered. According to LPN #2, the evening nurses received report and were told which residents they were to follow up on with laxatives.</p>			
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F 282	Continued From page 13  Per interview, she was unsure why she had not administered the dulcolax suppository on the evening of 07/12/14, as per the order and care plan. LPN #2 stated Resident #3 started having loose stools around 12:00 AM on 07/13/14 and had several loose stools after that. Continued interview revealed she did an abdominal assessment but, was not sure if she had checked the rectum digitally for stool. LPN #2 stated she failed to document her abdominal/bowel assessment of Resident #3. Continued interview with LPN #2, revealed Resident #3 became ashen and clammy and she notified the Physician who ordered the resident to be sent to the ER.  Interview on with RN #2 01/29/15 at 12:06 PM revealed she was the Charge Nurse on the days she worked. She stated, the facility had a bowel protocol in place where on the morning of the third day of a resident not having a BM, MOM would be administered, and the evening of the third day without a BM a dulcolax suppository would be administered. Continued interview revealed if no BM by the fourth day, a Fleets Enema would be administered and the Physician would be notified. She further stated she printed off a bowel list each morning and gave it to the nurses who were assigned to administer medications. Further interview revealed the nurses were to document the medications given on the MAR and also any results of the laxatives and was to pass the information on in report to the next shift. RN #2 stated she did not always follow up to see if the nurses had administered the pm laxatives and whether the residents had results from the laxative. Continued interview revealed Resident #3 should have had MOM given on 07/12/14 on the day shift and a dulcolax suppository on the evening of 07/12/14; however,	F 282			

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F 262	<p>Continued From page 14</p> <p>there was no documented evidence the medications were given as ordered and as per the care plan intervention.</p> <p>interview with the Director of Nursing, on 01/30/15 at 5:36 PM, revealed Resident #3 should have been monitored per the care plan including a abdominal/bowel assessment if she/he was not having BM's at least every three (3) days.</p> <p>2. Review of Resident #4's medical record revealed diagnoses which included Alzheimer's Disease, Frequent Urinary Tract Infections, and Constipation. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/23/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of six (6), which was indicative of being cognitively impaired. Continued review of the MDS revealed the facility assessed the resident to require extensive assistance of two (2) staff for toileting and to be frequently incontinent of bowel and bladder.</p> <p>Review of the resident's Physician Orders, dated 01/05/15, revealed Resident #4 was prescribed to have Milk of Magnesia, 30ML by mouth as needed if there was no bowel movement in three (3) days. Staff was instructed to administered the MOM the morning of the third (3rd) day. Continued review revealed the resident was to receive an Enema, one (1) rectally daily, as needed, for constipation after four (4) days of no bowel movement.</p> <p>Review of Resident #4's Comprehensive Plan of Care dated 12/09/13, revealed Resident #4 was at risk for a bowel elimination problem related to</p>	F 262		
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F 282	<p>Continued From page 15</p> <p>decreased mobility, constipation, side effects of medication, and Alzheimer's Disease. The goal stated the resident would have a regular BM pattern as evidenced by soft/formed stool at least every three (3) days. There were several interventions including: monitor bowel movement status, report changes in BM status to the Physician, and administer bowel regimen per Physician's Orders.</p> <p>Review of the computerized "Elimination Report" for Resident #4 revealed the resident did not have a BM for four (4) days, from 12/18/14 to 12/21/14. Further review of the resident's chart revealed there was no documented evidence the resident was administered medication to relieve the resident of his/her bowels for the four (4) days he/she had gone without a BM as per the care plan.</p> <p>3. Review of Resident #5's medical record revealed diagnoses which included Anxiety, Hypertension, Mood Disorder, Failure to Thrive, and Senile Dementia. Review of the Significant Change MDS Assessment dated 01/06/15, revealed the facility assessed the resident as having a BIMS score of twelve (12), which was indicative of the resident being cognitively aware. Continued review of the MDS revealed the facility assessed the resident to require extensive assistance of two (2) staff for toileting and to be occasionally incontinent of bladder and was always continent of bowel.</p> <p>Review of Resident #5's Physician's orders, dated 12/02/14, revealed the resident was prescribed Milk of Magnesia Suspension 30ML by mouth every three (3) days as needed if there were no results from the prune juice. Continued review of</p>	F 282		
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F 282	Continued From page 16 the Physician's order revealed the resident was prescribed Bisac-Evac 10MG Suppository rectally in the AM of day four (4) if there was no result from the Milk of Magnesia.  Review of Resident #4's Comprehensive Care Plan, dated 12/27/13, revealed a problem that Resident #5 was at risk for a bowel elimination related to decreased mobility and side effects of medication. The goal stated the resident would have a regular BM pattern as evidenced by soft/formed stool at least every three (3) days. There were several interventions including: monitor bowel movement status, report changes in BM status to the Physician, and administer bowel regimen per Physician's Orders. Continued review of the chart revealed there was no documented evidence the resident received his/her medications as prescribed.  Review of the computerized "Elimination Report" for Resident #5 revealed the resident did not have a BM for four (4) days, from 12/04/14 to 12/07/14 and from 12/08/14 through 12/11/14 and 01/13/15 through 01/15/15. Further review of the resident's chart revealed there was no documented evidence the resident was administered medication to relieve the resident of his/her bowels for the four (4) days he/she had gone without a BM as per the care plan.  4. Review of Resident #7's medical record revealed diagnoses which included history of Constipation, Dementia, Brain Syndrome, and Diabetes. Review of the Quarterly MDS Assessment dated 01/26/15, revealed the facility assessed the resident as being severely cognitively impaired. Continued review of the MDS revealed the facility assessed the resident	F 282		
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F 282	<p>Continued From page 17</p> <p>to require extensive assistance of two (2) staff for toileting and to be always incontinent of bowel and bladder.</p> <p>Review of the resident's MAR, dated 01/01/15 to 01/31/15, revealed the resident was prescribed Milk of Magnesia Suspension Magnesium Hydroxide. It was to be given to the resident, 30 ML by mouth as needed if the resident did not have a BM in three (3) days. Continued review revealed the resident also had a Physician's order for Dulcolax Suppository. If there was no bowel movement by the evening of day three (3), the Dulcolax was to be administered per rectum.</p> <p>Review of the Comprehensive Plan of Care dated 02/28/14, revealed Resident #7 was at risk for a bowel elimination problem related to occasional constipation, decreased mobility, Congestive Heart Failure, Alzheimer's, and side effects of medication. The goal stated the resident would have a regular BM pattern as evidenced by soft/formed stool at least every three (3) days. There were several interventions including: monitor bowel movement status, report changes in BM status to physician, and administer bowel regimen per Physician's Orders. Continued review of the resident's record revealed there was no documented evidence the resident received his/her medication as prescribed as per physician's order and facility's policy.</p> <p>Review of the computerized "Elimination Report" for Resident #7 revealed the resident did not have a BM for four (4) days, from 01/23/15 to 01/27/15. Further review of the resident's chart revealed there was no documented evidence the resident was administered medication to relieve the resident of his/her bowels for the five (5) days</p>	F 282		
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F 282	Continued From page 18 he/she had gone without a BM as per the care plan.  interview with the Director of Nursing (DON), on 01/30/14 at approximately 6:45 PM, revealed the Bowel Protocol and care plan was not followed for Residents' #4, #5, and #7, but should have been.  Continued interview with the DON, on 01/30/15 at 5:35 PM, revealed her expectation was for each resident to have a BM at least every three (3) days. The DON stated, the current policy was not followed and the policy needed to be revised. Continued interview, revealed each morning the charge nurse printed a bowel list which showed which residents had not had a BM in the past forty-eight (48) hours which was kept at the nurse's station. The DON revealed the facility followed the three (3) day rule and if a resident had no BM by the morning of the third day the protocol should be started. Per interview, the Charge Nurses no longer followed up to see if the PRN (as needed) laxatives were administered because they no longer used Certified Medication Tech's (CMT's), and the medication nurses were to monitor residents' BM's and PRN laxatives for effectiveness. She further stated the care plans should have been followed and the nurses on the medication carts were responsible for ensuring this was done related to the bowel protocol.	F 282			
F 309 SS=E	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	F 309			

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P 309	<p>Continued From page 19 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure necessary care and services were provided for residents physical well-being for four (4) of ten (10) sampled residents (Resident #3 #4, #5 and #7),.....</p> <p>The facility failed to follow the bowel protocol for Resident #3 who did not have a bowel movement (BM) for four (4) days, from 07/09/14 until 07/13/14. On 07/13/14, Resident #3 was noted to have several loose stools, became ashen and clammy and was sent to the hospital Emergency Room (ER) where the resident was diagnosed with a Fecal impaction and a Urinary Tract Infection (UTI).</p> <p>In addition, the facility failed to provide documented evidence Residents #4, #5, and #7 experienced BM's as per the facility's policy for "Bowel Movement Regimen". These residents experienced three (3) days or greater time periods of no documented BMs; however, there was no documented evidence the facility followed the "Bowel Movement Regimen" policy, regarding administration of bowel medications as ordered by the Physician for residents who had not had regular BMs.</p> <p>The findings include:  Review of the facility's policy titled, "Bowel</p>	F 309	<p>F309</p> <p>1. The Director of Nursing reviewed 483.25, Provide Services and Care for the highest well being. Each resident will receive and the facility will 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. The Staff Development Coordinator educated the licensed nurses on 1/30/15 regarding the physical well-being of Residents #3, #4, #5, and #7 with specifics regarding consistent bowel movements, and following physician orders and Plan of Care. On 1/30/15, the Assistant Director of Nursing completed an abdominal/bowel assessment on Residents #3, #4, #5, and #7 to ensure physical well-being was maintained. The Attending Physician/Medical Director was notified of the findings on 1/30/15 by the Director of Nursing.</p> <p>2. On 2/20/15, the Director of Nursing/Assistant Director of Nursing completed an audit on all residents' bowel elimination records, physician orders, Medication Administration Records, and care plans to ensure that all orders were</p>	2/21/15
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5263 ASBURY ROAD AUGUSTA, KY 41002
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F 309 Continued From page 20  
Movement (BM) Regimen", undated, revealed the facility would monitor and track residents on a daily basis to determine the need for dietary and/or chemical interventions to treat chronic and/or acute episodes of constipation. Per the Policy, the facility would implement appropriate interventions as identified on the resident's individualized care plan, Physician's Orders, and/or dietary recommendations. The Policy noted the suggested interventions included if no BM for two (2) days the resident would receive additional high fiber drink and/or food supplements such as four (4) ounces of prune juice. Continued review revealed if still no BM the following would be initiated: on day three (3) the resident was to be given prune juice with breakfast and Milk of Magnesia (MOM) thirty (30) milliliters (ml) in the AM (morning) of day three (3); if no BM by the evening of day three (3), the resident was to be given Dulcolax suppositories per rectum; if no BM by the AM of day four (4), the resident was to receive a Fleets Enema per rectum. Further review revealed if the resident had no results from the enema, notify the Physician for additional orders.

F 309 being followed to ensure compliance with attaining and/or maintaining the highest practicable physical, mental, and psychosocial well-being of all residents. The attending physician was notified and new orders were obtained for those residents identified as needing changes to their routine bowel regimen.

3. On 1/30/15, the Staff Development Coordinator completed an in-service with all licensed nurses regarding the physical, mental, and psychosocial well-being of all residents, general and specific to consistent bowel movements, and following physician orders and care plans. The Director of Nursing/Assistant Director of Nursing revised the Bowel Policy and Procedure on 2/20/15. The Staff Development Coordinator conducted a written in-service to the licensed nursing staff on 2/20/15 regarding the newly revised Bowel Policy and Procedure. The licensed nursing staff were also provided a copy of the revised Bowel Policy. The Medical Director approved the revised Bowel Policy and Procedure on 2/20/15. All licensed nurses will adhere to the revised Bowel Policy and Comprehensive Plan of Care for each resident.

Additional review of the facility's policy titled, "Bowel Movement (BM) Regimen", undated, revealed the Certified Nursing Assistants (CNAs) would record all residents' BM's on the CNA Assignment Sheet or facility specified form. Per the Policy, the 11:00 PM to 7:00 AM CNA would transcribe the BM record to the Tracking Form and give it to the Charge Nurse, who would utilize the BM Tracking Form at the beginning of their shift to identify residents who had not had a BM in more than forty-eight (48) hours. Review revealed the Charge Nurse would implement the appropriate regimen for the resident. According

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Mar. 2, 2015 5:15PM

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F 309	<p>Continued From page 21</p> <p>to the Policy, residents identified as needing initiation of the bowel protocol would be placed on the Twenty-Four (24) Hour Report by the Charge Nurse. The Policy revealed any medical interventions would be recorded on the Medication Administration Record (MAR), interventions would be documented and the Charge Nurse would follow up with the MAR to ensure interventions had been documented by the staff member. Further review revealed the Attending Physician/Designee would be notified on all residents who did not have a BM within four (4) days. Additionally, the Policy revealed during the clinical meetings, the Interdisciplinary Team (IDT) would ensure all residents were assessed for constipation and provided needed dietary and hydration interventions, and the residents's Care Plan would be revised with all appropriate interventions.</p> <p>1. Review of Resident #3's medical record revealed the facility admitted him/her on 04/17/07, with diagnoses which included Non-Alzheimer's Dementia, Osteoporosis, Atrial Fibrillation and Failure to Thrive. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/10/14, revealed the facility assessed the resident as having both short and long term memory loss. Continued review of the MDS revealed the facility assessed the resident to require total dependence of two (2) staff for toileting and to be always incontinent of bowel and bladder.</p> <p>Review of the Comprehensive Care Plan dated 10/17/13, revealed Resident #3 had a care plan for his/her risk for a bowel elimination problem related to decreased mobility, side effects of medication, Alzheimer's Disease, and decreased</p>	F 309	<p>4. The Director of Nursing/designee will monitor 100% of residents' bowel movements twice daily 5 days a week X one month, then 2 times a week X 2 months, including the size and consistency of bowel movements, to ensure each resident has a bowel movement occurring at least every 3 days per policy, new orders are obtained as needed, and to ensure the newly revised bowel policy and care plan is being followed as written. The Director of Nursing/designee will review each resident's individual bowel elimination record during the morning IDT clinical meeting to review each resident's last documented bowel movement, including size and consistency. The Director of Nursing/designee will communicate the findings with the medication nurse and the charge nurse for review and comparison of their bowel elimination exception report. The Director of Nursing/designee will follow up with the medication nurse at the end of his/her shift to ensure the Bowel Policy and Care Plan was followed and determine if a call to the attending physician is needed. The results of these audits will be reviewed in the daily clinical meeting by the IDT. The results will also be reported to the Quality Assurance Committee for review and any concerns addressed immediately.</p>	

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F 309	<p>Continued From page 22</p> <p>liquid intake. Continued review of the care plan revealed the goal stated Resident #3 would have a regular BM pattern as evidenced by soft/formed stool at least every three (3) days. Review revealed several interventions which included administering the bowel regimen as per Physician's Orders, monitoring the resident's BM status and reporting changes in his/her BM status to the Physician.</p> <p>Review of Resident #3's Physician's Orders for July 2014, revealed the following orders: Nutrisource Fiber Powder (a fiber supplement) by mouth daily; Senna Laxative (a laxative medication) by mouth daily; Milk of Magnesia (MOM) (a laxative medication) if no BM by the morning of day three (3), give 30 milliliters (mls) as needed; Bisac-Evac ten (10) milligram (mg) suppository rectally if no BM by the evening of day three (3); and an Enema rectally as needed if no BM in the morning (AM) of day four (4), then call the Physician.</p> <p>Review of the facility's computerized "Elimination Report" for Resident #3 revealed the resident had a medium soft BM on 07/09/14, which was documented at 12:28 AM. Continued review of the "Elimination Report" revealed no documented evidence Resident #3 had another BM until 7/13/14, four (4) days later, when documentation revealed the resident had a large loose BM at 12:02 AM.</p> <p>Review of Resident #3's Medication Administration Record (MAR) dated July 2014, revealed the resident received MOM 30 ml on 07/11/14 which was documented to have "no effect". However, review of the MAR revealed no documented evidence MOM 30 ml was</p>	F 309		

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F 309	<p>Continued From page 23</p> <p>administered on 07/12/14, day three (3) of no documented BM. Continued review revealed no documented evidence Resident #3 received the Bisac-Evac suppository rectally as ordered if no BM by the evening of day three (3), which was 07/12/14.</p> <p>Review of the Nurse's Notes dated 07/13/14 at 2:00 AM revealed Resident #3 had several loose stools that night and had been "moaning" when having the stools. Review of the Nurse's Note on 07/13/14 at 2:50 AM, revealed the nurse was called to the room by the CNA and the resident was noted to be ashen and clammy, with his/her blood pressure 125/97, pulse 89 and respirations 20. Review of the 07/13/14 at 3:00 AM and 3:30 AM, Nurse's Notes revealed the Physician was notified and the resident was transported to the hospital ER. Further review of the Nurse's Notes from 07/11/14 through 07/13/14, revealed no documented evidence an abdominal/bowel assessment was completed, even though according to the "Elimination Report", Resident #3 had no documented BM on day three (3), 7/12/14. In addition, review of the Nurse's Notes revealed no documented evidence an abdominal/bowel assessment was performed on 07/13/14, when Resident #3 was "moaning" with the loose stools.</p> <p>Review of the Hospital Discharge Instructions dated 07/13/14, revealed Resident #3 was diagnosed with a Fecal Impaction and a Urinary Tract Infection (UTI) and received an EKG (an electrocardiogram, a test that checks for problems with the electrical activity of the heart), Cardiac Monitoring, Laboratory (lab) tests, x-rays of the abdomen and chest, a Cat Scan (computerized axial tomography) of the Abdomen</p>	F 309		

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F 309	<p>Continued From page 24 and Pelvis, and a Fleets Enema.</p> <p>Interview with Registered Nurse (RN) #1 on 01/29/15 at 12:00 PM, revealed she was assigned to Resident #3 on the day shift on 07/11/14 and 07/12/14. Per interview, the Charge Nurse printed out a bowel list of residents who had not experienced a BM on day three (3) or four (4). She reported giving Resident #3 MOM 30 ml 07/11/14 at 4:35 PM, but was not sure why she gave the medication since that was just day two (2) of no BM. According to RN #1, she should have given Resident #3 MOM on 07/12/14, which would have been day three (3) without a BM. Continued interview revealed she asked the CNA's each morning if the residents on the bowel list had experienced a BM or not, and if the resident had a BM which was not documented yet that morning, she would not give the laxative. Further interview revealed she did not perform abdominal assessments of residents before giving prn (as needed) laxatives, she just gave the medications as per the orders and the protocol.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 01/28/15 at 5:44 PM, revealed she was assigned to Resident #3 on 07/12/14 from 7:00 PM to 7:00 AM on 07/13/14. She stated, according to Resident #3's Physician's Orders, the resident should have received a dulcolax suppository on the evening of day three (3) without a BM which would have been 07/12/14; however, according to the MAR for that date, the medication was not administered as ordered. Per interview, the evening nurses received report and were told which residents they were to follow up on with laxatives. Continued interview revealed she was unsure why she had not administered</p>	F 309		

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F 309	<p>Continued From page 25</p> <p>the dulcolax suppository on the evening of 07/12/13. LPN #2 stated Resident #3 started having loose stools around 12:00 AM on 07/13/14 and had several loose stools. She stated, she did an abdominal assessment including listening for bowel sounds in all four (4) quadrants and checking the resident's abdomen for firmness, but was not sure if she had checked his/her rectum digitally for stool. According to LPN #2, Resident #3 had bowel sounds in all four (4) quadrants of the abdomen, and the abdomen was soft and non-distended. However, she stated she failed to document any of her abdominal/bowel assessment of Resident #3. Further interview revealed Resident #3 became clammy and ashen, so she notified the Physician and sent the resident to the hospital ER.</p> <p>Interview with RN #2 on 01/29/15 at 12:06 PM, revealed she was the Charge Nurse on days she worked, and the facility had a bowel protocol which was for residents to have MCM administered on the morning of the third day without a BM and a dulcolax suppository administered on the evening of the third day without a BM. Per interview, if the resident had no BM by the fourth day per the protocol, a Fleet's Enema would be administered and the Physician would be notified. She stated she printed off a bowel list each morning and gave it to the nurses who were assigned to administer medications. Continued interview revealed the nurses were to document the medications given on the MAR, note any results of the laxatives and pass the information on in report to the next shift. RN #2 stated she did not always follow up to see if the nurses had administered the laxatives pm and whether the residents had results. Further interview revealed Resident #3 should have had</p>	F 309		
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Mar. 2. 2015 5:17PM

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F 309	<p>Continued From page 26</p> <p>MOM given on 07/12/14, on the day shift and a dulcolax suppository on the evening of 07/12/14. She stated however, there was no documented evidence the medications were given as ordered.</p> <p>2. Review of Resident #4's medical record revealed diagnoses which included Alzheimer's Disease, Frequent Urinary Tract Infections (UTIs), and Neuropathy. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/23/15, revealed the facility assessed Resident #4 as having a Brief Interview for Mental Status (BIMS) score of six (6), which was indicative of being severely cognitively impaired. Continued review of the MDS revealed the facility assessed Resident #4 to require extensive assistance of two (2) staff for toileting and to be frequently incontinent of bowel and bladder.</p> <p>Review of the Comprehensive Care Plan, dated 12/09/13, revealed Resident #4 was at risk for a bowel elimination problem related to decreased mobility, constipation, side effects of medication, and Alzheimer's Disease. Per the care plan, the goal stated Resident #4 would have a regular BM pattern as evidenced by soft/formed stool at least every three (3) days. Continued review of the care plan revealed there were several interventions including monitor BM status, report changes in BM status to the Physician, and administer the bowel regimen as per Physician's Orders.</p> <p>Review of the computerized "Elimination Report", from 12/01/14 to 01/27/14, revealed Resident #4 had no documented evidence of a BM from 12/18/14 to 12/21/14, a period of three (3) days.</p> <p>Review of the MAR dated, 12/01/14 to 12/31/14,</p>	F 309		
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F 309	<p>Continued From page 27</p> <p>revealed Resident #4 was prescribed MOM 30 mls by mouth as needed if the resident did not have a BM in three (3) days, and an order for Bisac-Evac 10 mg suppository rectally on the evening of day three (3) of no BM. However, further review of the MAR revealed no documented evidence Resident #4 was given the MOM or Bisac-Evac suppository as per Physician's Order and the facility's "Bowel Movement (BM) Regimen" policy.</p> <p>3. Review of Resident #5's medical record revealed diagnoses which included Hypertension, Failure to Thrive and Senile Dementia. Review of the Significant Change MDS Assessment dated, 01/08/15, revealed the facility assessed the resident as having a BIMS score of twelve (12), which was indicative of being moderately cognitively impaired. Continued review of the MDS revealed the facility assessed Resident #5 to require extensive assistance of two (2) staff for toileting and to be occasionally incontinent of bladder and was always continent of bowel.</p> <p>Review of the Comprehensive Care Plan dated 12/27/13, revealed the facility care planned Resident #5 to be at risk for a bowel elimination problem related to decreased mobility and side effects of medication. Per the care plan, the goal stated Resident #5 would have a regular BM pattern as evidenced by soft/formed stool at least every three (3) days. Further review of the care plan revealed several interventions which included monitoring his/her bowel movement status, reporting changes in BM status to the Physician, and administering the bowel regimen as per Physician's Orders.</p> <p>Review of the computerized "Elimination Report",</p>	F 309		
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F 309	Continued From page 28 from 12/01/14 to 01/27/14, revealed Resident #5 had no documented evidence of a BM: from 12/04/14 through 12/07/14, a three (3) day period; from 12/08/14 through 12/11/14, a three (3) day period; and from 01/13/15 through 01/16/15, a three (3) day period.  Review of the MARs dated 12/01/14 to 12/31/14 and 01/01/15 through 01/31/15, revealed Resident #5 was prescribed MOM 30 ml by mouth as needed if no BM in three (3) days, and Bisac-Evac 10 mg suppository rectally every three (3) days as needed for no BM by the evening of day three (3). However, further review of the MAR revealed no documented evidence the MOM or Bisac-Evac suppository were administered as per the Physician's Orders and the facility's "Bowel Movement (BM) Regimen" policy.  4. Review of Resident #7's medical record revealed diagnoses which included a History of Constipation, Dementia and Diabetes. Review of the Quarterly MDS Assessment dated 01/26/15, revealed the facility assessed Resident #7 as being severely cognitively impaired. Continued review of the MDS revealed the facility assessed the resident to require extensive assistance of two (2) staff for toileting and to be always incontinent of bowel and bladder.  Review of Resident #7's Comprehensive Care Plan dated 02/28/14, revealed the facility care planned the resident to be at risk for a bowel elimination problem related to occasional constipation, decreased mobility, diagnoses of Congestive Heart Failure and Alzheimer's, and side effects of medication. Per the care plan, the goal stated Resident #7 would have a regular BM	F 309			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 29 pattern as evidenced by soft/formed stool at least every three (3) days. Further review of the care plan revealed interventions which included administering the bowel regimen as per Physician's Orders, monitoring the resident's BM status and reporting changes in BM status to the Physician.  Review of the computerized "Elimination Report", from 12/01/14 to 01/27/14, revealed Resident #7 had no documented evidence of a BM from 01/23/15 through 01/27/15, a four day period.  Review of Resident #7's MAR dated 01/01/15 through 01/31/15, revealed Resident #7 was prescribed MOM 30 ml by mouth as needed if no BM in three (3) days, and Bisac-Evac 10 mg suppository rectally every three (3) days as needed for no BM by the evening of day three (3). However, further review of the MAR revealed no documented evidence the MOM or Bisac-Evac suppository were administered as per the Physician's Orders and the facility's "Bowel Movement (BM) Regimen" policy.  Interview on 01/30/15 at 5:35-PM and at 6:45-PM, with the Director of Nursing (DON) revealed it was her expectation each resident have a BM at least every three (3) days. She revealed the care plan and the Physician's Orders should have been followed related to Resident #3. In addition, the DON explained Resident #3 should have been monitored including a abdominal/bowel assessment if she/he was not having BM's at least every three (3) days. Per interview, the Bowel Protocol was not followed for Residents #4, #5, and #7, but should have been. The DON stated the current policy needed to be revised, but had not been followed. Continued interview	F 309		

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F 309	Continued From page 30 revealed since the facility utilized computerized documentation by the CNA's the BM Tracking Form indicated in the Bowel Regimen policy was no longer in use. She revealed the Charge Nurse printed a bowel list each morning which showed residents who had not had a BM in the past forty-eight (48) hours. According to the DON, the bowel list was kept at the nurse's station on a clipboard, and a copy was given to the medication nurses. The DON stated the nurses did not utilize the 24 Hour Report as indicated in the Bowel Regimen policy anymore related to the bowel protocol. She revealed a three (3) day rule was followed where if a resident had no BM the morning of the third day, the protocol should be started. Further interview revealed the Charge Nurses no longer followed up as indicated in the Bowel Regimen policy to see if the prn laxatives were administered. She stated this was because the facility no longer used Certified Medication Techs (CMT's) and only had medication nurses now on the medication carts.	F 309			
F 441 SS-D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441  1. The Director of Nursing/Assistant Director of Nursing reviewed 483.65 (a)(b)(c), Infection Control. The facility will prevent the spread of infection by maintaining a safe, sanitary, and comfortable environment. On 1/28/15, the Staff Development Coordinator immediately in-serviced the nursing staff on duty regarding the infection control policy and hand-washing policy. Resident #3 was	2/24/15	

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F 441	Continued From page 31 (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a sanitary environment and help prevent the development and transmission of disease and infection for one (1) of three (3) sampled residents (Resident #3) who were observed for skin assessments out of a total of ten (10) sampled residents.  Observation of the nurse performing Resident	F 441	assessed on 1/28/15 by the Assistant Director of Nursing for any signs and symptoms of infection. There were no negative outcomes identified. The Staff Development Coordinator also initiated a written in-service for all stakeholders on 1/28/15 on Infection Control, preventing the spread of infection.  2. On 2/18/15, the Staff Development Coordinator/Director of Nursing completed a skin assessment observation on all licensed nursing staff to ensure the Infection Control Policy and Procedures were being maintained. On 2/23/15, the Staff Development Coordinator completed bathing and perineal care competencies with all nursing staff. 100% of residents were observed and and/or interviewed by the Director of Nursing/Assistant Director of Nursing on 2/2/15 for signs and symptoms of infection.  3. On 1/28/15, the Staff Development Coordinator completed an in-service with all nursing staff to ensure understanding of the infection control policy. The Staff Development Coordinator implemented bathing, perineal care, and skin assessment competencies into the new hire orientation checklist on 2/2/15.		

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F 441	Continued From page 32 #3's skin assessment revealed the nurse used poor infection control technique as evidenced by failure to remove soiled glove, wash/sanitize hands and don new gloves.  The findings include:  Review of the facility's policy titled, "Handwashing", effective December 2010, revealed staff should wash their hands as necessary to prevent the spread of infections or germs.  Review of Resident #3's medical record revealed the facility admitted the resident on 04/17/07, with diagnoses which included Acute Kidney Failure, Osteomalacia and Cerebrovascular Insufficiency. Review of the Minimum Data Set (MDS) Assessment dated 12/10/14 revealed the facility assessed the resident to have short term and long term memory loss.  Observation on 01/28/15 at 9:40 AM, of a skin assessment for Resident #3, performed by Licensed Practical Nurse (LPN) #1, revealed the nurse assessed the resident's head, upper-torso and legs. Continued observation revealed the nurse then moved to the resident's feet and assessed the feet, palpating the feet and checking between his/her toes. Further observation revealed then, without removing her soiled gloves, washing her hands and donning new gloves, LPN #1 assessed the resident's perineal area.  Interview with LPN #1 on 01/28/15 at 9:50 AM, revealed she had not washed or sanitized her hands after assessing Resident #3's feet and prior to assessing the resident's perineal area.	F 441	4. The Director of Nursing/designee will monitor/observe skin assessments and wound care completed by the licensed nurses 5 times a week x 2 weeks, then weekly x 2 weeks, then monthly x 2 months to ensure compliance with the infection control policy, with attention to handwashing and appropriate donning, removal, and changing of gloves during care. The SDC/designee will complete infection control audits with the Certified Nursing Assistants during bathing and perineal care 5 times a week x 2 weeks, weekly x 2 weeks, then monthly x 2 months. The Dietary Manager/designee will conduct infection control audits during food prep (cooking and tray line) weekly x one month, then monthly x 2 months ensuring compliance with the infection control program. The audits will include proper handwashing and handling of food. The SDC/designee will continue to track and trend infections daily. The results of these audits will be forwarded by the Staff Development Coordinator/designee to the daily clinical meeting for review. The results will also be reported to the Quality Assurance Committee for review and any identified concerns will be addressed immediately.	
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F 441	Continued From page 33 However, she stated she could see how it would be important to have washed her hands prior to assessing Resident #3's perineal area to prevent the spread of infection.  Interview, on 01/30/15 at 5:35 PM, with the Director of Nursing (DON), revealed the nurse should have washed her hands and changed her gloves prior to assessing Resident #3's perineal area as that was an infection control issue and to prevent a Urinary Tract Infection (UTI's) which could be caused as a result.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to have a system in place to provide a safe, functional, sanitary, and a comfortable environment for residents, staff and the public as evidenced by observations revealed  The findings include:  Review of the facility's policy titled, "Plant Operations Policy and Procedure Manual Maintenance/Maintenance Service", dated January 2005, revealed it was the policy for maintenance service to be provided to all areas of the building, grounds and equipment. The Policy	F 465	F465 1. The Director of Nursing and Administrator reviewed 483.70 (h). The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. On 2/20/15, the Staff Development Coordinator educated all staff on environmental maintenance and what constitutes a work order to be initiated and directed to the Plant Operations Director. Examples were identified and presented to the staff on what would require a work order to be initiated. The ceiling tile noted with a brown substance in the dining room was replaced by the Administrator on 2/23/15. On 2/23/15, the handrail located close to the entrance door was sanded down by the Administrator to prevent residents or visitors from getting a splinter. The dust	2/24/15

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F 465	<p>Continued From page 34</p> <p>revealed the maintenance department was responsible for maintaining the buildings grounds and equipment in a safe and operable manner at all times. Additionally, the Policy revealed maintenance was responsible for maintaining the building in good repair and free from hazards and for providing routinely scheduled maintenance service to all areas of the facility.</p> <p>Review of the facility's policy titled, "Plant Operations Policy and Procedure Manual Maintenance/Work Orders", dated January 2005, revealed in order to establish a priority of maintenance service, work orders were to be filled out and forwarded to the Maintenance Director. Per the Policy, it was the responsibility of the Department Directors or any staff member to identify needed repairs, fill out and forward work orders for the repairs to the Maintenance Director. Continued review of the Policy revealed a supply of work orders would be maintained at each nurse's station. The Policy noted any work order requests completed would be placed in the appropriate file basket at the nurse's station, and the work orders would be picked up daily.</p> <p>Observation during the facility tour, 01/28/15 at 9:15 AM, revealed: a brown substance was located on the tiles of the ceiling in the dining room; a handrail located close to the entrance door had a hanging splinter; dust and clutter were present throughout the laundry room; with food and staff's personal items in the "folding" area of the residents' laundry. Additionally, observation revealed cracked tile in the residents' shower room and a missing piece of the shower covering which exposed the plastic and wire pieces when the shower was turned on.</p>	F 465	<p>and clutter were removed throughout the laundry room on 1/30/15 by the Administrator and Housekeeping staff. The housekeeping staff were educated by the Administrator/Staff Development Coordinator on 1/29/15 regarding keeping the "folding" area of the residents' laundry clean and free of any staff member's personal items or food. A new shower covering was purchased and installed by the Administrator on 2/23/15. The cracked tile in the residents' shower room was repaired by the Administrator on 2/23/15.</p> <p>2. The Administrator/Plant Operations Director completed a facility walk-through on 2/3/15 to identify any further potential areas in need of improvement. The Administrator/Plant Operations Director will develop a facility walk-through schedule with the new full-time Plant Operations Director upon hire, to be completed by the Plant Operations Director and the Administrator together at a minimum of a monthly basis.</p>	
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F 455	Continued From page 35  Interview with Housekeeper #1, on 01/28/15 at 9:25 PM, revealed the housekeepers did not formally have a cleaning schedule and cleaned whatever needed to be cleaned as necessary. She reported she thought maintenance would clean the dust observed on the walls, outlets, and pipes of the laundry room. Per interview, she had not filled out a work order for items that needed to be repaired and/or cleaned. Continued interview revealed she was still learning her role as a housekeeper and she had been without a Housekeeping Supervisor to provide guidance. Further interview revealed staff should not have stored food or personal items in the "folding" area of the laundry room.  Interview with the Plant Operations Director (POD), on 01/28/15 at 11:45 AM, revealed the brown substance from the ceiling tile in the dining room appeared to from water leakage somewhere. The POD revealed the handrail should have been sanded down to prevent residents or visitors from getting a splinter. Per interview, he assisted the facility once a week, until the facility could hire a full time maintenance person. He revealed he made a "walk through" of the facility once a week and would check into any repairs or maintenance requested. The POD stated he was not aware of the dust/rust observed in the laundry room, the cracked tile in the shower room and the missing shower protector on the shower and all of the other maintenance concerns observed by the Surveyor. Additionally, he added if staff noticed areas where the facility should be repaired, they should have filled out a work order so he would have been aware of the maintenance concerns.  Interview with the Administrator, on 01/30/15 at	F 455	3. The Administrator reviewed and revised the housekeeping cleaning schedule on 2/19/15. The housekeeping staff was educated by the Staff Development Coordinator/Administrator on 2/19/15 on the newly revised cleaning schedule for daily completion. The completed daily cleaning schedule will be submitted to the Administrator and/or Plant Operations Director daily for review. The housekeeping staff were educated on 1/29/15 by the Staff Development Coordinator on the work order policy and procedure with examples provided to include hand rail maintenance, clean ceiling tiles, etc. The Administrator reviewed and revised the routine maintenance cleaning schedule for all non-resident areas on 2/19/15. The Administrator will educate the new Plant Operations Director of the routine maintenance cleaning schedule upon hire.  4. The Administrator/Plant Operations Director/designee will complete a weekly facility walk through x one month, then bi-weekly x 2 months, and ongoing, to ensure the facility provides a safe, sanitary, functional, and comfortable environment. The results of the facility "walk throughs" will be reported to the Quality Assurance Committee and any concerns will be		

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F 455	Continued From page 36 9:00 AM, revealed the process for informing maintenance of work requests was for staff to fill out a maintenance request log. Continued interview revealed the POD would make a list of items which needed to be repaired, and the POD would take care of them. The Administrator added, "there were not a lot of maintenance requests" at the facility. He stated the POD was responsible for logging the items needing to be repaired to ensure the repairs were done. Per interview, the POD came to the facility once a week and the Regional POD would come once a week also to make any repairs. The Administrator revealed he would call contractors for larger jobs and would repair smaller jobs himself. According to the Administrator, staff should make a request for maintenance once they noticed items within the building needing to be repaired. Further interview with the Administrator revealed he did not believe there was a cleaning schedule for the laundry, and dusting in the laundry room would be part of the POD's routine maintenance. The Administrator reported it would be his expectation for staff not to leave personal items or food in the "folding area" of the laundry room. He stated staff had lockers to store their items in and break rooms in which they could eat. The Administrator stated this was important to prevent cross contamination.	F 455	addressed immediately. The facility "walk through" results will also be used for educational purposes for all staff to understand the Work Order Policy and Procedure. The Administrator/designee will monitor/audit the laundry room and the "folding" area of the residents' clean laundry 5 times a week x one month, then weekly x 2 months, to ensure compliance with a safe, functional, sanitary, and comfortable environment. The results of these audits will be reported to the Quality Assurance Committee for review and immediately addressed as needed.	
F 502 SS-D	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	F502  1. The Director of Nursing reviewed 2/21/15 483.75(j)(1), Administration. The facility will provide or obtain laboratory services to meet the needs of its residents. The facility will be responsible for the quality and	

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F 502	<p>Continued From page 37</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure there was an effective system in place to ensure laboratory (lab) orders were obtained as ordered for one (1) of ten (10) sampled residents (Resident #6). Resident #6 had a lab order to obtain a Dilantin (anti-seizure medication) level which was ordered for 11/21/14; however, was not obtained as ordered.</p> <p>Additionally, observation during tour of the medication room revealed expired lab specimen containers stored in medication room.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy, "Laboratory Processes and Procedures At-A-Glance", undated, revealed lab orders would be transcribed by the nurse in the following manner: the lab/diagnostic test would be written on the lab/diagnostic tracking form and lab calendar; communicated to the lab via the computer; and placed on the specific resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR). Per the Policy, the nurse would complete the appropriate lab/diagnostic requisition and place it in the file for the lab technician. Continued review revealed the Assistant Director of Nursing (ADON) would review all new Physician Orders daily and compare to the laboratory log, lab calendar, tracking book and resident's MAR/TAR. Review revealed as Physician's Orders were reviewed in the daily clinical meeting, the team would again review to ensure the order had been transcribed and translated appropriately. Further review of</li> </ol>	F 502	<p>timeliness of the services. The Attending Physician/Medical Director was notified by the Director of Nursing on 1/29/15 of the missed lab (Dilantin level) on Resident #6. The Director of Nursing completed an assessment on Resident #6 on 1/29/15 with no concerns identified. A follow up Dilantin level was ordered by the attending physician to be obtained on 2/2/15. The Director of Nursing reviewed Resident #6's physical assessment, physician orders, and care plan with the Attending Physician on 1/29/15. The Director of Nursing/Assistant Director of Nursing reviewed Resident #6's complete chart to audit for all lab orders to ensure no other labs were missed and/or incomplete. No other missed labs were identified. The Staff Development Coordinator immediately in-serviced the licensed nursing staff on the Lab Policy and Procedure on 1/29/15. All expired lab tubes/supplies were removed from the medication room on 1/29/15 by the Director of Nursing. The lab tubes had not been in use over the past year. Health Alliance Lab Services completes all lab services in the facility, using their own supplies. The Medical Director/Attending Physician was provided direct access to the Health Alliance Laboratory online site for</p>	
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002		
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F 502	Continued From page 38 the Policy revealed each day the ADON and the Clinical Team were to follow up on all lab/diagnostic tests to ensure they had been completed, results were returned timely and communicated to the Physician.  Record review revealed the facility admitted Resident #6 on 11/08/14, with diagnoses which included Convulsions (Seizures) and Alcohol Liver Damage. Review of the admission Physician's Orders for Resident #6 revealed the orders included Dilantin 400 milligram (mg) once a day. Review of the 11/19/14 verbal Telephone Order (TO) timed 5:30 PM, revealed Registered Nurse (RN) #3 had received the order, which was to increase Resident #6's Dilantin dose to 400 mg by mouth in the AM (morning) and to give Dilantin 200 mg at bedtime. Continued review of the 11/19/14 verbal TO revealed Resident #6 was to have a lab obtained for a Dilantin level on 11/21/14. Continued record review revealed the increase in Resident #6's Dilantin medication was transcribed. However, further record review revealed no documented evidence the TO was transcribed as per the facility's policy regarding the lab order for the Dilantin level, or of lab results for the lab ordered to be obtained on 11/21/14.  Interview with Laboratory Personnel #2 on 01/29/15 at 5:30 PM, revealed the lab did not have any record of having received an order on 11/19/14, to obtain a Dilantin level for Resident #6 on 11/21/14. Laboratory Personnel #2 stated therefore, the lab did not complete a Dilantin level for Resident #6 on 11/21/14.  Interview with RN #3 on 01/29/15 at 5:40 PM, revealed she remembered putting the verbal TO for the lab into the computer after receiving the	F 502	Immediate access to lab orders and lab results on 2/16/15 by the Director of Nursing.  2. The Director of Nursing, Assistant Director of Nursing, and Health Information Manager completed a lab audit on 1/30/15 of all lab orders on all residents for the previous quarter. Each resident's chart was reviewed for lab results, each physician order reviewed for lab orders, and notification of the attending physician noted. There were no further missing labs identified in the audit. All supplies located/stored in the Medication Room were audited for expiration by the Director of Nursing and Central Supply Director on 2/2/15. Any expired items identified were immediately removed from the medication room by the Director of Nursing and disposed of.		

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:  185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002
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F 502	<p>Continued From page 39</p> <p>order on 11/19/14; however, did not know what happened. She stated maybe there was a glitch in the computer system and that was why it never reached the lab. Per interview, she did not know why she didn't chart receiving the order in a Nurse's Note in Resident #6's medical record. RN #3 revealed she was aware of the facility's policy for transcribing Physician's Orders for medication and lab orders, but could not recall why she didn't follow the policy and transcribe the lab order correctly.</p> <p>Interview, on 01/29/15 at 5:50 PM and on 01/30/15 at 5:30 PM, with the Director of Nursing (DON) revealed the facility's process was for the nurses to put the lab orders into the computer system. She stated all new Physician's Orders were reviewed Monday through Friday in the clinical management meeting. Per interview, however, "somehow" a copy of Resident #6's lab order was not received and taken to the clinical management meeting to ensure the lab was completed as ordered. The DON revealed the lab order was not taken off correctly, was not placed in the lab tracking binder, and a copy of the order was not placed in the new order folder at the nursing station as per the facility's policy.</p> <p>2. Interview with the Director of Nursing on 01/29/14 at 5:50 PM, revealed the facility had no policy for storing lab specimen containers.</p> <p>Observation, on 01/29/15 at 12:15 PM, of the medication room revealed the following expired lab containers: five (5) BD Vacutainer venipuncture containers which expired September 2014; five (5) Star Swab II containers which expired 09/21/14; one (1) Star Swab II container which expired 09/25/14; one (1)</p>	F 502	<p>3. On 2/6/15, the Staff Development Coordinator educated all licensed nursing staff on the Lab Policy and Procedure, including obtaining the order, transcribing the order to the Treatment Administration Record, recording the lab in the Lab Tracking binder, placing the lab due on the Nurse's Station calendar, and inputting the lab with date due into the Health Alliance Laboratory Services online requisition form. The Lab Tracking binder information is now included in the Acute Daily Charting Book located at the Nurse's Station. Carbon copies of any new physician order will be placed in an envelope labeled "Orders" and kept at the nurse's station. The licensed nurses return demonstrated the Lab Policy and Procedure with revisions to the Staff Development Coordinator on 2/6/15. Effective 2/20/15, the Central Supply Director was educated by the Director of Nursing and is responsible for monitoring the medication room for expired supplies and removal of any expired supplies.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5289 ASBURY ROAD AUGUSTA, KY 41002
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 502	<p>Continued From page 40</p> <p>Universal Viral Transport container which expired August 2014; twenty-three (23) red Vacutainer containers which expired October 2013; nineteen (19) red Vacutainer containers which expired 07/02/14; and thirty-eight (38) lavender Vacutainer which expired July 2014.</p> <p>Interview, on 01/29/14 at 12:30 PM, with Licensed Practical Nurse (LPN) # 2 revealed she did not really know who was responsible for checking the "lab tubes". Per interview, the "lab tubes" were never checked that she was aware of as the lab always obtained all the blood specimens. LPN #2 stated the facility staff obtained only the urine specimens for urinalysis (U/A), culture and sensitivity (C&amp;S), and any swabs required.</p> <p>Interview, on 01/29/14 at 12:50 PM, with RN #2 revealed the facility staff did not "draw" labs there as the lab took "care of all of that". Per interview, if a "stat" lab was ordered the nurses called the lab for them to come and collect the specimen.</p> <p>Interview with the DON on 01/23/14 at 5:50 PM, revealed she just checked the "lab tubes" herself "last week", and thought she had "cleared all of that out (expired "lab tubes)". Per interview, the facility really didn't have a system for checking to ensure "lab tubes" were not expired, and she would have to "look into that".</p>	F 502	<p>4. The Director of Nursing/Designee will audit 100% of charts daily 5 days a week x one month, then 2 times a week x two months, to ensure compliance with the Laboratory Policy and Procedure and to ensure that each new physician order is noted by the Director of Nursing/Designee. The Administrator will monitor the Laboratory Process daily x one month by utilizing the Performance Improvement Quality Assurance Form. The Director of Nursing/Designee will audit the medication room weekly x 3 months to ensure compliance with removal of all expired supplies. The results of these audits will be forwarded to the daily clinical meeting for review and immediate intervention as needed. The results will also be reported to the Quality Assurance Committee for review and any concerns addressed immediately.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

*Acceptable*

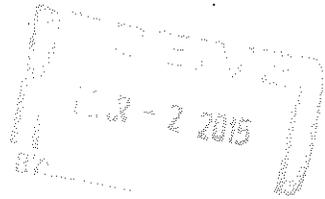
PRINTED: 02/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING (01 - MAIN BUILDING) 01  B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Survey under: NFPA 101 (2000 Edition)  Plan approval: 1964  Facility type: SNF/NF  Type of structure: One (1) story with partial basement, Type V (000)  Smoke Compartment: Three (3)  Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, heat detectors in basement and boiler room.  Sprinkler System: Complete sprinkler system (wet).  Generator: Type 2 generator powered by natural gas.	K 000		
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	A Standard Life Safety Code Survey (using 2786S Short Form) was concluded on 01/29/2015. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was twenty-eight (28). The facility is licensed for thirty-two (32) beds.			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Amy McWhorter RN</i>	TITLE <i>RN DON</i>	(X6) DATE <i>2/23/15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 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.

No. 2374 P. 2

Mar. 2, 2015 5:07PM