

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2011
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NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
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F-000	INITIAL COMMENTS	F 000	This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.	9/9/11
F 309 SS=D	<p>483.25. PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for one (1) of five (5) sampled residents, (Resident #1). The facility failed to assess Resident #1 after an episode of emesis and congestion was reported.</p> <p>The findings include: Review of Resident #1's medical record revealed the facility admitted Resident #1 the facility on 11/18/07 with diagnoses which included Achalasia (Inability of certain hollow, muscular organs to contract) of Esophagus, Esophageal Reflux, and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/14/11, revealed the facility assessed Resident</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> The facility was unable to provide corrective action for the resident identified as #1 due to death. All facility residents were re-assessed to assure no change in condition that warranted an assessment and/or physician notification. No further deficient practices were identified. This assessment was completed by the IDT team by 9/1/11. Employee #1 and ADON was re-educated upon notification during the survey process. The Executive Director and Director of Health Services provided additional education to the employee in regards to providing a prompt response and assessment on any patient presenting with a change in condition. The training with employee #1 and ADON was completed by 8/25/11. The Director of Health Services conducted a training session with the LPN's and RN's to discuss the nursing standard of care in providing a prompt response and assessment on any patient presenting with a change in condition. The nursing staff has been instructed to begin a Change in Condition monitoring record if a resident presents with any change in condition. This training was completed by 8/11/11. The IDT reviewed all current care plans to ensure "usual/normal occurrences/behaviors" are addressed with appropriate interventions. The facility alleges compliance as of 9/9/11. The Director of Health Services and Executive Director will conducted daily periodic rounds with the nursing staff throughout shift to ensure that any individual presenting with a change in condition has received a timely assessment with interventions implemented, if necessary, including notification of physician. The facility alleges compliance as 9/9/11. The facility will monitor compliance through the daily CQI process which will identify residents with a Change in Condition from the past 24 hours. The IDT will ensure that the proper documentation for Change in Condition 	9/9/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *NHA, ED* (X8) DATE: *9/2/11*

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

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F 309	<p>Continued From page 1</p> <p>#1 as severely cognitively impaired.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/08/11 at 2:00 PM, revealed Resident #1 would experience emesis sporadically as a result of his/her Achalasia of Esophagus. The ADON went on to reveal that when Resident #1's episodes of emesis began occurring more often, it was a strong indicator that Resident #1 needed a Botox Injection to open up his/her esophageal sphincter.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 08/08/11 at 2:54 PM, revealed Resident #1 would have episodes of emesis on average 2 days a week, more frequently if needing a Botox treatment. Follow up interview, on 08/10/11 at 2:23 PM, revealed Resident #1's vomiting could be a one-time episode, and that vomiting twice in a day was not out of the ordinary.</p> <p>Review of nursing notes, dated 07/25/11, reveal at 1:00 PM staff reported to LPN #1 that Resident #1 had vomited during lunch. Review of the nursing notes revealed no evidence that Resident #1 was assessed at that time.</p> <p>An interview with LPN #1, on 08/08/11 at 2:54 PM, revealed she assessed Resident #1 on 07/25/11 after lunch, at which time Resident #1 was breathing fine and talking while at the nurses' station. LPN #1 stated Resident #1 exhibited no signs or symptoms of distress at that time.</p> <p>An interview with Certified Nursing Assistant (CNA) #4, on 08/09/11 at 2:47 PM, who cared for Resident #1, revealed she told LPN #1 on 07/28/11 between 2:30 PM and 3:00 PM that</p>	F 309	<p>has been implemented by nursing staff with proper documentation present and proper notification, treatment implemented as ordered, if necessary. The facility alleges compliance as of 9/9/11.</p> <p>8. As a component of the ongoing compliance, the IDT will monitor during the CQI process that any resident identified with medical conditions that may contribute to a change in condition, will have that diagnosis documented on the Care Plan with all appropriate interventions to ensure the necessary care and services are provided to maintain the highest practicable physical, mental and psychosocial well-being. The facility alleges compliance as of 9/9/11.</p> <p>9. The ED or Designee will utilize a circumstance monitoring tool daily during the IDT CQI process to ensure compliance with patient assessment triggered by change in condition form. The facility alleges overall compliance as of 9/9/11.</p>	

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F 309	<p>Continued From page 2</p> <p>Resident #1 had vomited again and was congested, while CNA #1 stayed with Resident #1 and cleaned him/her up. CNA #4 revealed the Advanced Registered Nurse Practitioner (ARNP) was at the nurses station as well. Further, CNA #1 revealed she spoke with the Assistant Director of Nursing (ADON) on the way back to Resident #1's room, informing her that Resident #1 had another episode of vomiting and was congested. CNA #4 went on to reveal the ADON instructed her to ensure Resident #1's head of bed was elevated.</p> <p>Further review of 07/25/11 nursing notes reveal at 2:45 PM staff reported to LPN #1 that Resident #1 had increasing emesis and possible congestion. Review of the notes revealed no evidence LPN #1 assessed Resident #1 following the report by staff. The nursing note went on to reveal Resident #1 was discovered by staff entering his/her room to prepare him/her to go to the dining room, at 3:35 PM, as having no signs of life. Staff informed LPN #1, who found Resident #1 to have no signs of life with cyanotic changes beginning to take place. Record review and interview revealed Resident #1 was a DNR.</p> <p>Interview with LPN #1, on 08/10/11 at 2:23 PM, revealed CNA #4 did not report Resident #1 as being in acute distress when she reported the emesis and congestion at 2:45 PM on 07/25/11. LPN #1 went on to state she had informed the ARNP of the situation, and the ARNP intended to see Resident #1 later that day. Continued interview with LPN #1 revealed Resident #1 had a history of emesis, and as long as he/she had the head of the bed elevated, aides to clean him/her up, and no signs of distress, then an immediate</p>	F 309		

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F 309	<p>Continued From page 3 assessment was not necessary.</p> <p>In an Interview with the Assistant Director of Nursing (ADON), on 08/08/11 at 2:00 PM, it was revealed that Resident #1 had a history of emesis, which would happen "sporadically", and it was not a significant change in Resident #1's condition. Interview with the ADON, on 08/10/11 at 1:59 PM, revealed CNA #4 had also informed her that Resident #1 had an episode of emesis, but it was not presented in such a way to indicate Resident #1 was in any distress. The ADON stated she informed CNA #4 to make sure Resident #1' head of the bed was elevated.</p> <p>Interview with ARNP, on 08/10/11 at 1:03 PM, ARNP confirmed she was planning on seeing Resident #1 that evening before leaving the facility. The ARNP went on to reveal if she were in a nursing capacity, and was informed a resident experienced vomiting and congestion, she would check on the resident. Further interview revealed she was in the building and went to Resident #1 immediately upon a report of no signs of life. Further interview revealed the ARNP felt the cause of death was related to a heart condition because there were no signs of aspiration.</p> <p>Interview with LPN #2, on 08/10/11 at 10:00 AM, revealed she would assess a resident if staff informed her a resident had vomited again after vomiting previously.</p> <p>Review of Resident #1's Comprehensive Care Plan revealed no evidence the facility had developed a care plan for the assessment and interventions related to Resident #1's emesis,</p>	F 309		

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F 309	<p>Continued From page 4</p> <p>although this was mentioned by staff several times during the course of the investigation as normal behavior for Resident #1. Further interview with staff went on to consistently reveal Resident #1 had periodic Botox injections to act as a paralytic to keep his/her esophageal sphincter functioning properly. Review of the Comprehensive Care Plan revealed no evidence these problems were addressed.</p> <p>Interview with CNA #7, on 08/10/11 at 12:56 PM, revealed she last saw Resident #1 just after 3:00 PM when she arrived for work, revealing that Resident #1's appearance and breathing appeared normal at that time.</p> <p>Interview with the Funeral Home Director, on 08/10/11 at 10:04 AM, revealed no evidence of aspiration during post-mortem care.</p>	F 309		
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