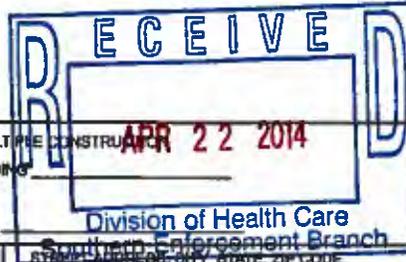


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 180005	(X2) MULTIPLE CONSTRUCTION: A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 03/20/2014
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 KENTUCKY ROUTE 321 PRESTONSBURG, KY 41653
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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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A 000	INITIAL COMMENTS A complaint investigation (KY21445) was initiated on 03/18/14 and concluded on 03/20/14. The complaint was substantiated. The facility was found to be out of compliance with the Conditions of Participation at 42 CFR 482.23 Nursing Services (A0385). Standard level deficiencies were identified at Patient Rights (A0131) and Nursing Services (A0395 and A0396). Interview and record review revealed the facility failed to ensure a Registered Nurse supervised and/or evaluated nursing care, and failed to ensure staff implemented the plan of care for one (1) of ten (10) sampled patients (Patient #1). A review of documentation revealed Registered Nurses failed to ensure staff provided residents assistance with turning, repositioning, and/or incontinence care, and failed to ensure nursing care plans were developed and implemented for Patient #1 resulting in an acute decompensation of the patient, admission to the Critical Care Unit, and the development of a Stage II pressure sore to the buttocks.	A 000	Please see attached Word Document	
A 131	Refer to A0131, A0395, and A0396. 482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the	A 131	1. Informed Consent training for Highlands nursing staff UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following: o What is informed consent? o Identify emergency situation related to informed consent; o Identify the persons authorized to consent to a procedure and/or treatment; o What procedures required consent? o What procedures specific to Behavioral Health required consent? o Documenting informed consent as related to psychotropic medication on the Behavioral Health Unit o Exhibit #1 Complete April 22 & 24, 2014	To be completed April 22 & 24, 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>NO C Warner</i>	TITLE PRES/CEO	(X6) DATE 4-14-2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 131	<p>Continued From page 1</p> <p>provision of treatment or services deemed medically unnecessary or inappropriate.</p> <p>This STANDARD is not met as evidenced by: Based on interview, record review, and facility policy review it was determined the facility failed to ensure an effective process was established for the patient or patient's representative/guardian to make informed decisions regarding medical interventions for one (1) of ten (10) sampled patients (Patient #1). Psychotropic medications (mood altering drugs that affect mental activity, behavior, and/or perception) were ordered and/or altered for Patient #1 without the consent of the patient's representative/guardian.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Psychotropic Medications," revised January 2014, revealed the purpose of the policy was for the protection and promotion of each patient's rights and to provide a procedure for informing patients about psychotropic medications. The policy revealed the patient and or patient representative/guardian had the right to be informed regarding their care in order to make informed decisions regarding their care planning and treatment, including requesting and/or refusing treatment. Further review of the policy revealed patients or patient representatives/guardians must be informed about actions and side effects of psychotropic medications before they could be administered and documentation of consent would be noted within the patient chart. The policy revealed the psychotropic drug consent form would be utilized for documentation and the appropriate medication/education sheet would be provided to the patient or patient's representative/guardian.</p>	A 131	<p>2. Quality Monitoring established for the validation of informed consent related to medical interventions of psychotropic medication(s) documentation</p> <ul style="list-style-type: none"> o This monitoring was established to address any non-conformity which will be addressed with each individual staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure documentation of the informed consent when a psychotropic medication is changed; o Exhibit #2 o Completed: April 21, 2014; Ongoing <p>3. Revised Behavioral Health Documentation Process</p> <ul style="list-style-type: none"> o The Behavioral Health documentation was revised to a narrative note by RN to provide more thorough documentation of observation, patient reassessment every 2 hours, validate special observation and changes in the patient's plan of care; o Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #3 o Completed: April 21, 2014; Ongoing 	<p>To be Completed April 21, 2014</p> <p>To be Completed April 21, 2014</p>	

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A 131	<p>Continued From page 2</p> <p>A review of Patient #1's medical record revealed the facility admitted Patient #1 on 02/28/14 with a diagnosis of Dementia with Behavioral Disturbances. Further review of the record revealed on 03/03/14, 2 milligrams (mg) of Valium (a benzodiazepine drug used to treat anxiety disorders) were ordered for Patient #1, two times a day (10:00 AM and 10:00 PM); on 03/11/14, the dosage was increased to 5 mg two times a day (10:00 AM and 10:00 PM). There was no evidence Patient #1's representative/guardian was informed about the order for Valium and no evidence consent for treatment was obtained for this medication prior to administering the medication to Patient #1.</p> <p>Further review of Patient #1's medical record revealed on 03/11/14, 30 mg of Remeron (an antidepressant medication used to treat major depressive disorder) were administered to Patient #1 without consent from the patient's representative/guardian or evidence that the patient's representative/guardian was informed about actions and side effects of the drug. In addition, 100 mg of Seroquel (a short-acting atypical antipsychotic drug approved for the treatment of schizophrenia and bipolar disorder) were administered to Patient #1 on 03/11/12 and 200 mg were administered on 03/12/14 without consent from the patient's representative/guardian or evidence the patient's representative/guardian was informed about the actions and side effects of the medication.</p> <p>Interview with Clinical Manager #1 on 03/19/14 at 12:30 PM revealed facility staff was required to also notify patients' representatives or guardians of changes in medications/treatments.</p>	A 131	<p>4. Protocol developed for patients to be assisted to ambulate or assisted back to bed after being in a seated position for more than two hours.</p> <ul style="list-style-type: none"> o Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #4 & Exhibit #2 o Completed: March 17, 2014; Ongoing <p>5. Psychotropic Medication training for Behavioral Health staff. Behavioral Health Nurse Practitioner to provide verbal and written education on the following:</p> <ul style="list-style-type: none"> o Justification of Psychotropic Medication, uses, and side effects to watch for; o Using the Pneumonic DELIRIUM to assess the underlying causes of delirium; o How to use the (CAM) Confusion Assessment Method to assess altered mental status due to delirium; o Comparison of the clinical features of Delirium, Dementia, and Depression; o Case study on assessing level of consciousness with a competency exam to see how well everyone is understanding information being presented; o Exhibit #6 o Completed: April 22 & 24, 2014 	<p>March 17, 2014</p> <p>To be Completed April 22 & 24, 2014</p>	

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A 131	Continued From page 3 However, further review of Patient #1's medical record revealed increases/changes were made in the dosage of psychotropic medications without notifying Patient #1's representative/guardian. On 03/01/14, consent was obtained from Patient #1's representative/guardian to administer Amitriptyline (a tricyclic antidepressant medication used to treat symptoms of depression). Although the dosage was not included on the consent form, staff administered 25 mg of Amitriptyline. However, on 03/06/14 the physician's order for Amitriptyline was changed to 100 mg at 2:00 PM and 150 mg at 10:00 PM; on 03/07/14 the Amitriptyline dosage was increased to 200 mg at 10:00 PM, and the AM dose discontinued; on 03/08/14, the Amitriptyline order was changed to 100 mg at 10:00 PM, and the AM dose discontinued on 03/10/14. There was no evidence Patient #1's representative/guardian was notified of the changes in the dosages of Amitriptyline that had been administered to Patient #1. On 03/01/14, consent was obtained from Patient #1's representative/guardian to administer Risperdal (an atypical antipsychotic drug that is mainly used to treat schizophrenia). The consent form did not identify the dosage or frequency of the medication; however, a review of Patient #1's physician orders revealed 0.25 mg of Risperdal, two times a day, was ordered for Patient #1. On 03/03/14 the order was increased to 0.5 mg of Risperdal, two times a day (10:00 AM and 10:00 PM); on 03/06/14 the dosage of Risperdal was increased to 1 mg two times a day (10:00 AM and 10:00 PM); on 03/11/14 the order was changed to 0.5 mg of Risperdal, two times a day (10:00 AM and 10:00 PM) and then discontinued at 10:02	A 131	6. Pressure ulcer education for Highlands Nursing Staff provided by Director of Nursing Operations/Risk. Education will be provide written and verbal information to included: o Identify how wounds are classified according to wound depth and etiology; o Describe the etiology of a pressure ulcer; o Understand evidenced-based protocols of care for prevention and management of pressure ulcers; o Describe appropriate Convatec products that can be used on wound characteristics, depth, and etiology; o April 22 & 24, 2014 7. Physician education provided on Medscape (on-line Physician CME Provider) on the following: o Participatory Medicine: Provider-Patient Communication o Beliefs & Communication Practices Regarding Cognitive Functioning Among Consumers and Primary Care Providers in the US o Advances in Treatment of Visual Hallucinations in Neurodegenerative Diseases o Best Practices for the Diagnosis and Treatment of Bipolar Depression o Exhibit #12 o Completed: April 10 & 11, 2014	To be Completed April 22 & 24, 2014 April 10 & 11, 2014	

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A 131	Continued From page 4 PM on 03/11/14. There was no evidence Patient #1's representative/guardian was notified of the changes in the antipsychotic medication. Interview with Patient #1's representative/guardian on 03/18/14 at 7:30 PM revealed the facility had changed Patient #1's medications and provided medical treatment without obtaining prior consent. Further interview with Clinical Manager #1 on 03/19/14 at 12:30 PM revealed facility staff was required to notify patients' representatives/guardians of changes in condition or changes in medications/treatment. The interview further revealed the clinical manager was aware that on numerous occasions during Patient #1's course of treatment, facility staff failed to obtain appropriate consent from Patient #1's representative before changes were made in psychotropic medications. Clinical Manager #1 gave no explanation why the consents had not been completed.	A 131	8. Highlands Nursing Staff training scheduled on various aspects of Patient Rights. UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following: o The Kentucky Laws; o What Patient Rights encompass; o When and How to inform patients of their rights; o The patient's role in their Rights; o Patient communication needs and their rights; o Legal Aspects o Exhibit #14 o April 22 & 24, 2014	To be Completed April 22 & 24, 2014	
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure a Registered Nurse supervised and/or evaluated the nursing care and implemented interventions identified on a care plan for one (1) of ten (10) sampled patients (Patient #1).	A 385	1. Informed Consent training for Highlands Nursing Staff (licensed). UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following: o What is informed consent? o Identify emergency situation related to informed consent; o Identify the persons authorized to consent to a procedure and/or treatment; o What procedures required consent? o What procedures specific to Behavioral Health required consent? o Documenting informed consent as related to psychotropic medication on the Behavioral Health Unit o Exhibit #1 o April 22 & 24, 2014	To be Completed April 22 & 24, 2014	

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A 385	<p>Continued From page 5</p> <p>Review of documentation revealed the facility admitted Patient #1 on 02/28/14 with diagnoses that included Dementia with Behavioral Disturbance and Depressed/Anxious Mood. A review of a nursing assessment conducted on the day of Patient #1's admission revealed the patient was continent of bowel and bladder. In addition, the assessment revealed the patient's skin was "within normal limits." Review of documentation revealed staff developed a Nursing Care Plan on 03/01/14 to address the patient's needs and assessed Patient #1 to have the potential for skin breakdown due to "altered tissue depletion." Review of interventions included on the care plan revealed staff was to inspect and document an assessment of the patient's skin upon admission and daily; implement measures to maintain urinary incontinence, e.g., to offer a bedpan, urinal, or assist the patient to the commode every two (2) to three (3) hours; and implement measures to decrease skin irritation resulting from incontinence or diarrhea. A review of a treatment plan dated 03/03/14 revealed Patient #1 had "good mobility." However, nursing staff failed to provide supervision to ensure the interventions identified on the Nursing Care Plan were implemented. Documentation revealed staff failed to assist Patient #1 to the commode every two (2) to three (3) hours to maintain urinary continence and failed to provide assistance with turning, repositioning, and incontinence care in an effort to prevent the development of pressure sores and/or skin breakdown.</p> <p>In addition, review of facility policy titled "Special Precautions Level II-Impulsive Behavior Precautions" revealed a procedure had been developed for patients who were viewed as a risk for "impulsive acts." According to the procedure,</p>	A 385	<p>2. Quality Monitoring established for the validation of informed consent related to medical interventions of psychotropic medication(s) documentation</p> <ul style="list-style-type: none"> o This monitoring was established to address any non-conformity which will be addressed with each individual staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure documentation of the informed consent when a psychotropic medication is changed; o Exhibit #2 o April 21, 2014; Ongoing <p>3. Revised Behavioral Health Documentation Process</p> <ul style="list-style-type: none"> o The Behavioral Health documentation was revised to a narrative note by RN to provide more thorough documentation of observation, patient reassessment every 2 hours, validate special observation and changes in the patient's plan of care; o Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #3 o April 21, 2014; Ongoing <p>4. Protocol developed for patients to be assisted to ambulate or assisted back to bed after being in a seated position for more than two hours.</p> <ul style="list-style-type: none"> o Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff; 	<p>To be Completed April 21, 2014</p> <p>To be Completed April 21, 2014</p>	

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A 385	Continued From page 6 "rounding for a purpose" would be made in the patient's chart every two (2) hours; and staff assigned to "Special Pre every fifteen procedure make an en (12) hours. However, nursing staff failed to provide supervision to ensure the patient was monitored every fifteen (15) minutes in accordance with the established procedure. Staff failed to document Patient #1 had been monitored every fifteen (15) minutes in accordance with the procedure between the hours of 1:45 PM and 3:55 PM on 03/12/14. Continued review of documentation revealed on the evening of 03/11/14 and the morning of 03/12/14 facility staff administered numerous medications to Patient #1 that included antipsychotics, antidepressants, and anti-anxiety medications. On the morning of 03/12/14, staff crushed the medications and placed the medications in applesauce when administered due to the patient's unresponsive behavior. On 03/12/14, the patient was observed to be unresponsive and at approximately 3:45 PM, the patient vomited brown emesis and was transferred to the Critical Care Unit (CCU). Documentation revealed at the time the patient was admitted to the CCU, staff documented Patient #1 had a Stage II pressure sore to the buttock area. Refer to A0395 and A0396.	A 385	9. Pressure ulcer education for Highlands Nursing Staff provided by Director of Nursing Operations/Risk Education will be provide written and verbal information to included: o Identify how wounds are classified according to wound depth and etiology; o Describe the etiology of a pressure ulcer; o Understand evidenced-based protocols of care for prevention and management of pressure ulcers; o Describe appropriate Convatec products that can be used on wound characteristics, depth, and etiology; 10. Quality Monitoring established to audit the medication alert report from the Cerner bar coding system. o This monitoring was established to audit any non-conformities which may be addressed with each individual staff as appropriate; o Clinical Managers will review a minimum of 12 records per week to monitor medication alerts; o Exhibit #10 o Completed: April 21, 2014; Ongoing	To be Completed April 22 & 24, 2014 To be Completed April 21, 2014	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE	A 395	A 395 begins on page 8 of 19		

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A 385	Continued From page 6 "rounding for a purpose" would be made in the patient's chart every two (2) hours; and staff assigned to monitor were to make an entry on the "Special Precautions, Patient Observation Record every fifteen (15) minutes." In addition, the procedure revealed the RN supervisor was to make an entry in the progress notes every twelve (12) hours. However, nursing staff failed to provide si Duplicate page needed to complete action plan patient was monitored in accordance with the procedure. Staff failed to document in accordance with the procedure between the hours of 1:45 PM and 3:55 PM on 03/12/14. Continued review of documentation revealed on the evening of 03/11/14 and the morning of 03/12/14 facility staff administered numerous medications to Patient #1 that included antipsychotics, antidepressants, and anti-anxiety medications. On the morning of 03/12/14, staff crushed the medications and placed the medications in applesauce when administered due to the patient's unresponsive behavior. On 03/12/14, the patient was observed to be unresponsive and at approximately 3:45 PM, the patient vomited brown emesis and was transferred to the Critical Care Unit (CCU). Documentation revealed at the time the patient was admitted to the CCU, staff documented Patient #1 had a Stage II pressure sore to the buttock area. Refer to A0395 and A0396.	A 385	13. Highlands Nursing Staff scheduled on various aspects of Patient Rights. UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following: o The Kentucky Laws; o What Patient Rights encompass; o When and How to inform patients of their rights; o The patient's role in their Rights; o Patient communication needs and their rights; o Legal Aspects o Exhibit #14 o April 22 & 24, 2014	To be Completed April 22, 24, 2014	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE	A 395	A 395 begins on page 8 of 19		

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A 395	<p>Continued From page 7</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure a Registered Nurse (RN) supervised and/or evaluated the nursing care for one (1) of ten (10) sampled patients (Patient #1). Review of documentation and interviews revealed Patient #1 was continent of bowel and bladder, ambulatory, oriented to person and place, and his/her skin was intact at the time of admission. Interviews and documentation revealed on 03/12/14, staff assisted Patient #1 up to a chair in the day area at 9:30 AM and the patient remained in the chair until 3:55 PM and was unresponsive. A review of nurse's notes and documentation on the facility's observation sheets revealed Registered Nurses failed to ensure staff offered the patient fluids; provided assistance to the bathroom; provided assistance with turning and repositioning; or provided incontinence care in an effort to prevent the development of pressure sores and/or skin breakdown. Based on documentation, on 03/12/14 at approximately 3:45 PM, the patient vomited brown stool and coffee ground material on the floor and walls of the Behavioral Unit and was transferred to the CCU. Documentation at the time the resident was admitted to the CCU revealed Patient #1 had a Stage II pressure sore to the buttock area.</p> <p>The findings include:</p> <p>Review of facility's policy titled "Hourly Rounding for a Purpose," revised 01/21/14, revealed nursing staff was to conduct "hourly" rounds and address each of the "four P's" (pain, position,</p>	A 395	<p>1. Informed Consent training for Highlands Nursing Staff (licensed). UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following:</p> <ul style="list-style-type: none"> o What is informed consent? o Identify emergency situation related to informed consent; o Identify the persons authorized to consent to a procedure and/or treatment; o What procedures required consent? o What procedures specific to Behavioral Health required consent? o Documenting informed consent as related to psychotropic medication on the Behavioral Health Unit o Exhibit #1 o April 22 & 24, 2014 <p>2. Quality Monitoring established for the validation of informed consent related to medical interventions of psychotropic medication(s) documentation</p> <ul style="list-style-type: none"> o This monitoring was established to address any non-conformity which will be addressed with each individual staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure documentation of the informed consent when a psychotropic medication is changed; o Exhibit #2 o April 21, 2014; Ongoing. 	<p>To be Completed April 22 & 24, 2014</p> <p>To be Completed April 21, 2014</p>	

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NAME OF PROVIDER OR SUPPLIER HIGHLANDS REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 KENTUCKY ROUTE 321 PRESTONSBURG, KY 41653		
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A 395	<p>Continued From page 8</p> <p>potty, and problems) on all patients. Nursing personnel were to specifically address the four P's and document in the medical record that the four P's had been addressed.</p> <p>Review of facility policy titled "Patient Observation Category: Special Precautions," revised January 2014, revealed the purpose of the policy was to ensure the patient was treated in the least restrictive environment that was clinically permitted and provided a means of monitoring to prevent the patient from harming themselves or others. Procedure II of the policy, "Special Precautions Level II-Impulsive Behavior Precautions" revealed the procedure was designed for patients who were viewed as a risk for "impulsive acts." According to the procedure, "rounding for a purpose will be made in the patient's chart every two (2) hours"; and staff assigned to monitor were to make an entry on the "Special Precautions, Patient Observation Record" every fifteen (15) minutes. In addition, the procedure revealed the RN supervisor was to make an entry in the progress notes every twelve (12) hours.</p> <p>A review of the medical record revealed the facility admitted Patient #1 on 02/28/14 with diagnoses of Dementia with behavioral disturbances, Adjustment Disorder with depressed/anxious mood, Chronic Obstructive Pulmonary Disease, Diabetes, Anemia, and Hypertension. A review of Patient #1's admission nursing assessment, dated 02/28/14, revealed the patient had no skin breakdown, was continent of bowel and bladder, was ambulatory, and oriented to person and place. Review of the Medication Administration Record (MAR) with the facility pharmacist revealed on the evening of</p>	A 395	<p>3. Revised Behavioral Health Documentation Process</p> <ul style="list-style-type: none"> o The Behavioral Health documentation was revised to a narrative note by RN to provide more thorough documentation of observation, patient reassessment every 2 hours, validate special observation and changes in the patient's plan of care; o Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #3 o April 21, 2014; Ongoing. <p>4. Protocol developed for patients to be assisted to ambulate or assisted back to bed after being in a seated position for more than two hours.</p> <ul style="list-style-type: none"> o Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #4 & Exhibit #2 o Completed: March 17, 2014; Ongoing 	To be Completed April 21, 2014	March 17, 2014

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A 395	Continued From page 11 facility's Rapid Response Team. Interview with RN #1 on 03/18/14 at 3:15 PM and on 03/19/14 at 4:30 PM revealed she was Patient #1's assigned nurse on 03/12/14. RN #1 stated when she began her shift at 7:00 AM on 03/12/14, Patient #1 was still asleep in bed. RN #1 stated between 8:30 AM and 9:00 AM, she and CNA #1 went to the patient's room to assist him/her out of bed and the patient was "sedated" and had been incontinent of stool. RN #1 stated Patient #1 had a red blanchable area on the buttocks with no broken area, and she placed a "gel cushion" in the chair when she transported the patient to the day room. RN #1 stated that she administered the patient's medications the morning of 03/12/14 and had to crush the medications and place them in applesauce because the patient was too sedated to swallow them intact. RN #1 stated staff fed the patient his/her breakfast and he/she ate approximately 50 percent of the meal, but could not recall if staff had offered the patient fluids or toileting every two hours during her shift on 03/12/14. RN #1 stated at approximately 4:00 PM, she and CNA #1 assisted Patient #1 back to the bedroom in the chair and used a mechanical lift to transfer the patient because the patient was unable to assist with the transfer. RN #1 stated that when they positioned Patient #1 to his/her side to position the mechanical lift in place, a brown liquid came out of the patient's mouth. At that time, according to RN #1, she thought the patient was "bleeding out" and instructed CNA #1 to monitor the patient's vital signs. RN #1 stated the patient's "vital signs" were "not good" and she requested assistance from the Rapid Response Team. Interview with Patient #1's medical physician on	A 395	9. Pressure ulcer education for Highlands Nursing Staff provided by Director of Nursing Operations/Risk. Education will be provide written and verbal information to included: o Identify how wounds are classified according to wound depth and etiology; o Describe the etiology of a pressure ulcer; o Understand evidenced-based protocols of care for prevention and management of pressure ulcers; o Describe appropriate Convatec products that can be used on wound characteristics, depth, and etiology; o April 22 & 24, 2014 10. Quality Monitoring established to audit the medication alert report from the Cerner bar coding system. o This monitoring was established to audit any non-conformities which may be addressed with each individual staff as appropriate; o Clinical Managers will review a minimum of 12 records per week to monitor medication alerts; o Exhibit #10 o April 21, 2014; Ongoing	To be Completed April 22 & 24, 2014 To be Completed April 21, 2014	

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A 395	<p>Continued From page 12</p> <p>03/18/14 at 4:30 PM revealed facility staff had not informed him of "any issues" and stated he was not aware of the pressure sore to the patient's buttocks prior to the patient's admission to the CCU. According to the physician, the decline in Patient #1's medical condition happened "suddenly."</p> <p>Interview with the attending Psychiatrist on 03/18/14 at 3:45 PM revealed Patient #1 was admitted to the Behavioral Health Unit from a local nursing home due to inappropriate sexual behavior and aggressiveness. According to the Psychiatrist, the patient's diagnoses included dementia with behavioral disturbances. The Psychiatrist stated he had adjusted the patient's medications to help with the patient's behaviors and difficulty sleeping. The interview further revealed that nursing staff never informed him of any concerns regarding Patient #1 being over sedated or any reported decompensation in the patient's condition. The Psychiatrist stated on 03/12/14, during morning rounds, he observed Patient #1 asleep while sitting in a chair in the common area of the Behavioral Unit. The Psychiatrist stated he touched the patient to awaken him/her and stated he/she mumbled something and went back to sleep. He stated he wasn't surprised by the presentation of the patient because of the medication changes, and stated, "Sometimes I over shoot the medicine; when patients come in walking, I want them to go out walking."</p> <p>Interview with the Clinical Manager for the Behavioral Health Unit on 03/18/14 at 11:50 AM revealed Patient #1 had been ambulatory, confused, and sexually inappropriate (verbally) upon the patient's admission to the Behavioral</p>	A 395	<p>11. Intake process updated to identify bowel movement patterns and dietary intake history.</p> <ul style="list-style-type: none"> o Director of Behavioral Health provided written and verbal education to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit # 11 & Exhibit #2 o Completed: March 27, 2014; Ongoing <p>12. Revised Behavioral Health Documentation Process</p> <ul style="list-style-type: none"> o The Behavioral Health documentation was revised to address bowel movements being observed by behavioral unit staff or reported by patient; o Director of Behavioral Health provided written and verbal education to Behavioral Health staff o Educated concerning the need for patient observation and not to solely rely on patient report of a bowel movement; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #13 & Exhibit #2 o Completed: March 19, 2014.Ongoing 	<p>March 27, 2014</p> <p>March 19, 2014</p>	

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A 395	<p>Continued From page 13</p> <p>Unit on 02/28/14. The interview further revealed the Psychiatrist adjusted Patient #1's medications numerous times due to the patient's sexually inappropriate behaviors. The Clinical Manager stated Patient #1's representative contacted him by telephone on 03/17/14 and voiced a complaint about the care Patient #1 received from staff on the Behavioral Unit and had asked the Clinical Manager how Patient #1 "ended up with poop in [his/her] lungs?" The Clinical Manager stated upon receipt of the complaint, he began an internal investigation, met with the Risk Manager, and also completed an incident report and placed the incident report in the facility's "system" per facility protocol. According to the Clinical Manager and documentation provided, the facility implemented a plan of correction on 03/17/14 that included re-education of facility staff related to monitoring the time a nonambulatory patient remained in a chair, policies on nursing rounds and skin assessments, patient observation categories, hourly rounding for a purpose, and patient rights. The Clinical Manager also stated that after the reported incident on 03/17/14 he began to monitor to ensure patients on the unit were not left in chairs for more than two (2) hours at a time and nurses followed facility protocol to prevent skin breakdown.</p> <p>Interview with the Risk Manager on 03/20/14 at 1:30 PM revealed that she became aware of the incident when Patient #1 was admitted to the CCU with a Stage II pressure ulcer and she began an internal investigation. The interview further revealed the Clinical Manager informed her of a complaint received from Patient #1's representative/guardian. She stated she reviewed the medical record for Patient #1 and identified concerns with staff's lack of</p>	A 395	<p>13. Highlands Nursing Staff training scheduled on various aspects of Patient Rights. UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following:</p> <ul style="list-style-type: none"> o The Kentucky Laws; o What Patient Rights encompass; o When and How to inform patients of their rights; o The patient's role in their Rights; o Patient communication needs and their rights; o Legal Aspects o Exhibit #14 o April 22 & 24, 2014 	To be Completed April 22 & 24, 2014	

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A 395	Continued From page 14	A 395			
A 396	<p>communication, documentation, and that nursing staff had not followed facility protocol regarding skin integrity and monitoring of patients.</p> <p>482.23(b)(4) NURSING CARE PLAN</p> <p>The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan</p> <p>This STANDARD 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 implement nursing care plans/interventions for one (1) of ten (10) sampled patients (Patient #1). A review of Patient #1's nursing assessment conducted on the day of admission, 02/28/14, revealed the patient was continent of bowel and bladder and the patient's skin was within normal limits with no skin breakdown noted. On 03/01/14, nursing staff developed a care plan and noted the patient had the potential for skin breakdown related to his/her "altered tissue depletion." Review of interventions on the care plan revealed staff was to inspect and document an assessment of the patient's skin upon admission and daily; implement measures to maintain urinary continence, e.g., to offer a bedpan, urinal, or assist the patient to the commode every two (2) to three (3) hours; and implement measures to decrease skin irritation resulting from incontinence or diarrhea. However, review of nursing documentation and interview with nursing staff revealed the facility failed to assist Patient #1 to the commode every two (2) to three (3) hours on 03/12/14 to maintain urinary continence and failed to provide assistance with turning,</p>	A 396	<p>1. Informed Consent training for Highlands Nursing Staff (licensed). UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following:</p> <ul style="list-style-type: none"> o What is informed consent? o Identify emergency situation related to informed consent; o Identify the persons authorized to consent to a procedure and/or treatment; o What procedures required consent? o What procedures specific to Behavioral Health required consent? o Documenting informed consent as related to psychotropic medication on the Behavioral Health Unit o Exhibit #1 o April 22 & 24, 2014 <p>2. Quality Monitoring established for the validation of informed consent related to medical interventions of psychotropic medication(s) documentation</p> <ul style="list-style-type: none"> o This monitoring was established to address any non-conformity which will be addressed with each individual staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure documentation of the informed consent when a psychotropic medication is changed; o Exhibit #2 o April 21, 2014; Ongoing 	<p>To be Completed April 22 & 24, 2014</p> <p>To be Completed April 21, 2014</p>	

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A 396	<p>Continued From page 15</p> <p>repositioning, and incontinence care in an effort to prevent the development of pressure sores and/or skin breakdown. In addition, review of facility policy titled "Special Precautions Level II-Impulsive Behavior Precautions" revealed a procedure for staff to monitor patients for impulsive behaviors and to make entries on the "Special Precautions, Patient Observation Record" every fifteen (15) minutes of the observations. The procedure revealed the RN supervisor was to make an entry in the progress notes every twelve (12) hours. However, staff failed to document Patient #1 had been monitored every fifteen (15) minutes in accordance with the procedure between the hours of 1:45 PM and 3:55 PM on 03/12/14.</p> <p>Continued review of documentation revealed Patient #1 was unresponsive during the day on 03/12/14, vomited, and his/her medical condition declined. Staff transferred the patient to the Critical Care Unit (CCU) at 4:00 PM. Documentation revealed at the time the patient was admitted to the CCU staff implemented emergency measures that included mechanical ventilation of Patient #1. In addition, staff documented Patient #1 had a Stage II pressure sore to the buttock area.</p> <p>The findings include:</p> <p>A review of facility policy titled "Nursing Care Plans," revised January 2014, revealed each patient had an individualized plan of care based on his/her needs and problems and initiated by the registered nurse. The plan would be evaluated and revised as indicated by the patient's response.</p>	A 396	<p>3. Revised Behavioral Health Documentation Process</p> <ul style="list-style-type: none"> o The Behavioral Health documentation was revised to a narrative note by RN to provide more thorough documentation of observation, patient reassessment every 2 hours, validate special observation and changes in the patient's plan of care; o Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #3 o April 21, 2014; Ongoing <p>4. Protocol developed for patients to be assisted to ambulate or assisted back to bed after being in a seated position for more than two hours.</p> <ul style="list-style-type: none"> o Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #4 & Exhibit #2 o Completed: March 17, 2014; Ongoing 	<p>To be Completed April 21, 2014</p> <p>March 17, 2014</p>	

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A 396	<p>Continued From page 16</p> <p>Review of facility policy titled "Special Precautions Level II-Impulsive Behavior Precautions" revealed a procedure had been developed for patients who were viewed as a risk for "impulsive acts." According to the procedure, "rounding for a purpose" would be made in the patient's chart every two (2) hours; and staff assigned to monitor was to make an entry on the "Special Precautions, Patient Observation Record every fifteen (15) minutes." In addition, the procedure revealed the RN supervisor was to make an entry in the progress notes every twelve (12) hours.</p> <p>Review of Patient #1's medical record revealed the facility admitted the patient on 02/28/14 with diagnoses of Dementia with behavioral disturbances, Adjustment Disorder with depressed/anxious mood, Chronic Obstructive Pulmonary Disease, Diabetes, Anemia, and Hypertension. A review of Patient #1's admission nursing assessment dated 02/28/14 revealed the patient had no skin breakdown, was continent of bowel and bladder, ambulatory, and oriented to person and place. Further review revealed staff developed a nursing care plan on 03/01/14 and noted the patient had the potential for skin breakdown related to his/her "altered tissue depletion." Interventions on the care plan revealed staff was to inspect and document an assessment of the patient's skin upon admission and daily. In addition, staff was to implement measures to maintain the patient's urinary continence that included offering the patient a bedpan, urinal, or to assist the patient to the commode, every two (2) to three (3) hours; and to implement measures to decrease irritation of the patient's skin that could be the result of incontinence or diarrhea. However, review of nursing documentation and interview with nursing</p>	A 396	<p>5. Protocol developed for vital signs to be obtained every 4 hours while awake. Any abnormal findings reported to physician.</p> <ul style="list-style-type: none"> o Modified care set to include vital signs every 4 hours while awake; o Director of Behavioral Health provided written and verbal education to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation; o Exhibit #5 & Exhibit #2 o Completed: April 1, 2014; Ongoing <p>6. Psychotropic Medication training for Behavioral Health staff. Behavioral Health Nurse Practitioner to provide verbal and written education on the following:</p> <ul style="list-style-type: none"> o Justification of Psychotropic Medication, uses, and side effects to watch for; o Using the Pneumonic DELIRIUM to assess the underlying causes of delirium; o How to use the (CAM) Confusion Assessment Method to assess altered mental status due to delirium; o Comparison of the clinical features of Delirium, Dementia, and Depression; o Case study on assessing level of consciousness with a competency exam to see how well everyone is understanding information being presented; o Exhibit #6 	<p>April 1, 2014</p> <p>To be Completed April 22 & 24, 2014</p>	

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A 396	<p>Continued From page 17</p> <p>staff revealed the facility failed to implement the interventions identified on the patient's care plan. Staff failed to assist Patient #1 to the commode every two (2) to three (3) hours on 03/12/14 in an effort to maintain the patient's urinary continence, and failed to provide the patient assistance with turning, repositioning, and incontinence care in an effort to prevent the development of pressure sores and/or skin breakdown. In addition, a review of documentation revealed staff failed to document Patient #1 had been monitored every fifteen (15) minutes between the hours of 1:45 PM and 3:55 PM on 03/12/14 in accordance with the facility's established "Special Precautions Level II-Impulsive Behavior Precautions" procedure.</p> <p>In addition, interviews and documentation revealed Patient #1 was unresponsive during the day on 03/12/14 and at approximately 3:45 PM, the patient vomited brown, coffee ground like material and was transferred to the Critical Care Unit (CCU) at 4:00 PM. Based on documentation, staff implemented emergency measures in the CCU that included mechanical ventilation of Patient #1. In addition, staff documented Patient #1 had a Stage II pressure sore to the buttock area.</p> <p>Certified Nursing Assistant (CNA) #1 stated in interview conducted on 03/18/14 at 4:40 PM she had provided care for Patient #1 on 03/12/14. CNA #1 stated she had monitored Patient #1 every fifteen (15) minutes on 03/12/14 but failed to document her observations past 1:45 PM because the unit was "so busy" and she was the only CNA on the floor. The CNA also stated that she did not recall if she offered fluids or bathroom to the patient every two hours as required on</p>	A 396	<p>7. Behavioral Health RN staff Refresher Training on adult assessment</p> <ul style="list-style-type: none"> o Refresher training provided to Behavioral Health Registered Nurses to enhance medical assessment skills <ul style="list-style-type: none"> ▪ Each RN will be mentored for 24 hours of refresher trainings utilizing the ADT (admission/discharge/treatment) RN; ▪ Competency Check-off to be completed for each RN; o Exhibit #7 o April 30, 2014 <p>8. Medication administration policy updated to reflect procedure for wasted or returned medication</p> <ul style="list-style-type: none"> o Director of Pharmacy to provide written and verbal education to staff on the following: <ul style="list-style-type: none"> ▪ Describe medication administration process as related to BCMA; ▪ Recognize BCMA alerts/symbols; ▪ List proper responses to BCMA alerts/symbols; ▪ Describe return for medications removed from Pyxis ▪ Describe return process for medications sent from Pharmacy; <p>Identify organizational drug reference resources</p> <ul style="list-style-type: none"> o Exhibit #8 o April 22 & 24, 2014 	<p>To be Completed April 30, 2014</p> <p>To be Completed April 22 & 24, 2014</p>	

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 180005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/20/2014
NAME OF PROVIDER OR SUPPLIER HIGHLANDS REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 KENTUCKY ROUTE 321 PRESTONSBURG, KY 41653		
(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	
A 396	Continued From page 18 03/12/14 as planned. Registered Nurse (RN) #1 stated in interview on 03/18/14 at 3:15 PM and on 03/19/14 at 4:30 PM that she had been assigned to provide care and supervision of Patient #1 on 03/12/14. RN #1 stated between 8:30 AM and 9:00 AM on 03/12/14, she and CNA #1 assisted Patient #1 out of bed and noted the patient had a red, blanchable area on the buttocks and placed a "gel cushion" in the chair when she transported the patient to the day room. RN #1 stated that she could not recall if staff had offered fluids or had offered to take the patient to the toilet every two hours as identified in the patient's care plan. Interview with the Clinical Manager for the Behavioral Health Unit on 03/18/14 at 11:50 AM revealed that based on documentation staff had not always implemented the interventions identified on the patient's care plan during the patient's admission to the facility. The Clinical Manager stated there had been a breakdown of communication and documentation and could offer no explanation why staff had failed to ensure Patient #1's care plan was implemented.	A 396	9. Pressure ulcer education for Highlands Nursing staff provided by Director of Nursing Operations/Risk Education will be provide written and verbal information to included: o Identify how wounds are classified according to wound depth and etiology; o Describe the etiology of a pressure ulcer; o Understand evidenced-based protocols of care for prevention and management of pressure ulcers; o Describe appropriate Convatec products that can be used on wound characteristics, depth, and etiology; o April 22 & 24, 2014 10. Quality Monitoring established to audit the medication alert report from the Cerner bar coding system. o This monitoring was established to audit any non-conformities which may be addressed with each individual staff as appropriate; o Clinical Managers will review a minimum of 12 records per week to monitor medication alerts; o Exhibit #10 o April 21, 2014; Ongoing 11. Intake process updated to identify bowel movement patterns and dietary intake history. o Director of Behavioral Health provided written and verbal education to Behavioral Health staff; o Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation;	To be Completed April 22 & 24, 2014 To be Completed April 21, 2014	

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Duplicate page needed to complete action plan

See the attached Word document. Highlighted areas indicate plan of correction for non-compliance during the auditing processes

A131, A 385, A395, A396 – CMS Action Plan _Behavioral Health_ID # - 18005)_3/14

- 1. Informed Consent training for Highlands Nursing Staff (licensed). UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following:**
 - What is informed consent?
 - Identify emergency situation related to informed consent;
 - Identify the persons authorized to consent to a procedure and/or treatment;
 - What procedures required consent?
 - What procedures specific to Behavioral Health required consent?
 - Documenting informed consent as related to psychotropic medication on the Behavioral Health Unit
 - Exhibit #1
 - Completed: April 22, 2014 and April 24, 2014

- 2. Quality Monitoring established for the validation of informed consent related to medical interventions of psychotropic medication(s) documentation**
 - This monitoring was established to address any non-conformity which will be addressed with each individual staff;
 - Director of Behavioral Health will review a minimum of 5 records per week to ensure documentation of the informed consent when a psychotropic medication is changed;
 - Any identified non-compliance will result in re-education of staff. Continued individual non-compliance will result in progressive discipline.
 - Exhibit #2
 - Completed: April 21, 2014; Ongoing

- 3. Revised Behavioral Health Documentation Process**
 - The Behavioral Health documentation was revised to a narrative note by RN to provide more thorough documentation of observation, patient reassessment every 2 hours, validate special observation and changes in the patient's plan of care;
 - Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff;

- Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation;
 - Any identified non-compliance will result in re-education of staff.
Continued individual non-compliance will result in progressive discipline.
 - Exhibit #3
 - Completed: April 30, 2014; Ongoing.
4. Protocol developed for patients to be assisted to ambulate or assisted back to bed after being in a seated position for more than two hours.
- Director of Behavioral Health provided written and verbal education provided to Behavioral Health staff;
 - Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation;
 - Any identified non-compliance will result in re-education of staff.
Continued individual non-compliance will result in progressive discipline.
 - Exhibit #4 & Exhibit #1
 - Completed: March 17, 2014; Ongoing
5. Protocol developed for vital signs to be obtained every 4 hours while awake. Any abnormal findings reported to physician.
- Modified care set to include vital signs every 4 hours while awake;
 - Director of Behavioral Health provided written and verbal education to Behavioral Health staff;
 - Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation;
 - Any identified non-compliance will result in re-education of staff.
Continued individual non-compliance will result in progressive discipline.
 - Exhibit #5 & Exhibit #1
 - Completed: April 1, 2014; Ongoing
6. Psychotropic Medication training for Behavioral Health staff. Behavioral Health Nurse Practitioner to provide verbal and written education on the following:
- Justification of Psychotropic Medication, uses, and side effects to watch for;
 - Using the Pneumonic DELIRIUM to assess the underlying causes of delirium;

- How to use the (CAM) Confusion Assessment Method to assess altered mental status due to delirium;
- Comparison of the clinical features of Delirium, Dementia, and Depression;
- Case study on assessing level of consciousness with a competency exam to see how well everyone is understanding information being presented;
- Exhibit #6
- Completed: April 22, 2014 and April 24, 2014

7. Behavioral Health RN staff Refresher Training on adult assessment

- Refresher training provided to BHI registered nurses to enhance medical assessment skills
 - Each RN will be mentored for 24 hours of refresher trainings utilizing the ADT (admission/discharge/treatment) RN;
 - Competency Check-off to be completed for each RN;
- Exhibit #7
- Completed: April 30, 2014

8. Medication administration policy updated to reflect procedure for wasted or returned medication

- Director of Pharmacy to provide written and verbal education to Highlands Nursing Staff (licensed) staff on the following:
 - Describe medication administration process as related to BCMA;
 - Recognize BCMA alerts/symbols;
 - List proper responses to BCMA alerts/symbols;
 - Describe return for medications removed from Pyxis
 - Describe return process for medications sent from Pharmacy;
 - Identify organizational drug reference resource
- Exhibit #8
- Training scheduled April 22 & April 24, 2014

9. Pressure ulcer education for Highlands Nursing Staff provided by Director of Nursing Operations/Risk. Education will be provide written and verbal information to included:

- Identify how wounds are classified according to wound depth and etiology;
- Describe the etiology of a pressure ulcer;

- Understand evidenced-based protocols of care for prevention and management of pressure ulcers;
- Describe appropriate Convatec products that can be used on wound characteristics, depth, and etiology;
- Training scheduled April 22 & April 24, 2014

10. Quality Monitoring established to audit the medication alert report from the Cerner bar coding system.

- This monitoring was established to audit any non-conformities which may be addressed with each individual staff as appropriate;
- Clinical Managers will review a minimum of 12 records per week to monitor medication alerts;
- Any identified non-compliance will result in re-education of staff. Continued individual non-compliance will result in progressive discipline.
- Exhibit #10
- Completed: April 21, 2014; Ongoing

11. Intake process updated to identify bowel movement patterns and dietary intake history.

- Director of Behavioral Health provided written and verbal education to Behavioral Health staff;
- Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation;
- Any identified non-compliance will result in re-education of staff. Continued individual non-compliance will result in progressive discipline.
- Exhibit # 11 & Exhibit #1
- Completed: March 27, 2014; Ongoing

12. Physician education provided on Medscape (On-line Physician CME Provider) on the following:

- Participatory Medicine: Provider-Patient Communication
- Beliefs & Communication Practices Regarding Cognitive Functioning Among Consumers and Primary Care Providers in the US
- Advances in Treatment of Visual Hallucinations in Neurodegenerative Diseases

- Best Practices for the Diagnosis and Treatment of Bipolar Depression
- Exhibit #12
- Completed: April 10 & 11, 2014

13. Revised Behavioral Health Documentation Process

- The Behavioral Health documentation was revised to address bowel movements being observed by behavioral unit staff or reported by patient;
- Director of Behavioral Health provided written and verbal education to Behavioral Health staff
- Educated concerning the need for patient observation and not to solely rely on patient report of a bowel movement;
- Director of Behavioral Health will review a minimum of 5 records per week to ensure proper documentation;
- Any identified non-compliance will result in re-education of staff. Continued individual non-compliance will result in progressive discipline.
- Exhibit #13 & Exhibit #1
- Completed: March 19, 2014, Ongoing

14. Highlands Nursing Staff training on various aspects of Patient Rights. UltraGroup Performance Improvement Coordinator to provide verbal and written education on the following:

- The Kentucky Laws;
- What Patient Rights encompass;
- When and How to inform patients of their rights;
- The patient's role in their Rights;
- Patient communication needs and their rights;
- Legal Aspects
- Exhibit #14
- Completed: April 22, 2014 and April 24, 2014

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Exhibit #1

Highlands Regional Medical Center

Policies and Procedures

OFFICE OF INSPECTOR GENERAL

Subject:	Informed Consent	Department: Administration
Scope:	Organization Wide	Original Policy Date: 01-2002
Regulatory Standard:	KY Rev. Stat 2.015 (311.631), CMS 482.13, 482.24 NIAHO Standard Patient Rights PR.4 Informed Consent	Revision Date: 04-18-05, 03-14-08, 02-03-2010, 12-28-12, 01-28-14
Location of Signed Original:	Administration	Page: 1 of 7

Author: Deanna Rice, RN 1/29/13
 Deanna Rice, RN, Director of Surgical Services Signature & Date

Approval Signature: Susan Ellis, RN, MSN 1/29/13
 Susan Ellis, RN, MSN, VP of Patient Care Services Signature & Date

Approval Signature: Margo Bays, RN 1/29/13
 Margo Bays, RN, Director of Nursing Operations / Risk Manager Signature & Date

Approval Signature: Harold C. Warman, JR. 1-29-14
 Harold C. Warman, JR., FACHE, President & CEO Signature & Date

PURPOSE

To provide guidance in regards to the informed consent process, including the roles and responsibilities of the treating provider (which could include any of the following: physician, surgeon, Licensed Independent Practitioner (LIP), proceduralist, anesthesia provider) as well as the Highlands Regional Medical Center (HRMC) staff. This policy will address any consent for procedures throughout the Medical Center, any all departments, and Inpatient as well as Outpatient. A "Consent for Admission and Treatment" will be obtained for all patients upon registration/admission, consenting for generalized care at the Medical Center.

To describe the procedures for:

1. Verifying and documenting the patient's consent for a procedure on the HRMC Consent for Operation or Procedure form
2. For handling special situations such as patients with limited English proficiency or emergency situations.
3. Identifying the persons authorized to consent to a procedure.

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POLICY

Highlands Regional Medical Center will take all reasonable steps to ensure the necessary consents for admission, hospital, and medical treatment are obtained in writing from the patient (or his/her legal representative) in accordance with the applicable standards, regulations, and laws of the State of Kentucky. Informed Consent will be obtained to document that a patient is consenting to a procedure. The Consent form should be signed and witnessed prior to the procedure but after the physician has completed the informed consent process. The consent form at HRMC is entitled, "Consent for Treatment/Procedure" and is referenced in and is apart of this policy.

PROCEDURE

The legal requirement that the patient's consent is necessary before medical treatment is rendered also requires that a patient or his legal guardian must be given sufficient information about the contemplated procedure so that consent given is an informed one. The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment.

I. The right to make informed decisions means that the patient or patient's representative is given the information needed in order to make "informed" decisions regarding his/her care. A patient may wish to delegate his/her right to make informed decisions to another person (as allowed under State law). (Interpretive Guidelines 482.13 (b) (2).

A. When a patient who is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must provide the designated individual with the information required to make an informed decision about the patient's care. The hospital must also seek the written consent of the patient's representative when informed consent is required for a care decision. The explicit designation of a representative by the patient takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless expressly withdrawn, either orally or in writing, by the patient.

B. In the case of a patient who is incapacitated, when an individual presents the hospital with an advance directive, medical power of attorney or similar document executed by the patient and designating an individual to make medical decisions for the patient when incapacitated, the hospital must, when presented with the document, provide the designated individual the information required to make informed decisions about the patient's care. The hospital must also seek the consent of the designated individual when informed consent is required for a care decision. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless the patient ceases to be incapacitated and expressly withdraws the designation either orally or in writing.

C. When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is not written advance directive on file or presented, and an individual asserts that he or

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she is the patient's spouse, domestic partner (whether or not formally established and including a same-sex domestic partner), parent (including someone who has stood in loco parentis for the patient who is a minor child), or other family member and thus is the patient's representative, the hospital will accept this assertion, without demanding supporting documentation, and provide the individual the information required to make informed decisions about the patient's care. The hospital will also seek the consent of the individual when informed consent is required for a care decision. We will treat the individual as the patient's representative unless:

1. More than one individual claims to be the patient's representative. In such cases, we will ask for documentation (examples may be; proof of legal marriage, domestic partnership, or civil union, proof of a joint household, proof of shared or co-mingled finances, and any other documentation the hospital considers evidence of a special relationship that indicates familiarity with the patient's preferences concerning medical treatment) from each individual supporting his/her claim. If more than one can provide this documentation, the patient will decide who will be their representative.

2. Treating the individual as the patient's representative without requesting supporting documentation would result in the hospital violating state law. State laws, including State regulations, may specify a procedure for determining who may be considered to be the incapacitated patient's representative, and may specify when documentation is or is not required.

3. The hospital has reasonable cause to believe that the individual is falsely claiming to be the patient's spouse, domestic partner, parent or other family member. Highlands Regional Medical Center will facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient's representative, given the critical role of the representative in exercising the patient's rights. Any refusal by the hospital of an individual's request to be treated as the patient's representative, based on one of the above-specified familial relationships must be documented in the patient's record, along with the specific basis for the refusal.

D. KY Law 311.631 states what responsible parties are authorized to make health care decisions:

1. If an adult patient whose physician has determined that he or she does not have decisional capacity has not executed an advance directive, or to the extent the advance directive does not address a decision that must be made, any one (1) of the following responsible parties, in the following order of priority if no individual in a prior class is reasonably available, willing and competent to act, shall be authorized to make health care decisions on behalf of the patient:

- a. The judicially-appointed guardian of the patient, if the guardian has been appointed and if medical decisions are within the scope of the guardianship;
- b. The attorney-in-fact named in a durable power of attorney, if the durable power of attorney specifically includes authority for health care decisions;
- c. The spouse of the patient

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d. An adult child of the patient, or if the patient has more than one (1) child, the majority of the adult children who are reasonably available for consultation;

e. The parents of the child

f. The nearest living relative of the patient, or if more than one (1) relative of the same relations is reasonably available for consultation, a majority of the nearest living relatives.

2. In any case in which a health care decision is made under this section, the decision shall be noted in writing in the patient's medical records.

3. An individual authorized to consent for another under this section shall act in good faith, in accordance with any advance directive executed by the individual who lacks decisional capacity, and in the best interest of the individual who does not have decisional capacity.

4. In any case in which a health care decision is made under this section, hospitalization for psychiatric treatment at general hospital shall not exceed fourteen (14) consecutive days unless a court order is obtained under KRS Chapter 202A or 202B. For the purposes of this section, a general hospital is one that is not owned or operated by the Commonwealth of Kentucky.

5. An individual authorized to make a health care decision under this section may authorize the withdrawal or withholding of artificially-provided nutrition and hydration only in the circumstances as set forth in KRS 311.629(3).

Effective: July 13, 2004

E. The proceduralist, or LIP, is a health care provider licensed by the state of Kentucky and duly qualified to provide independent care in the hospital. MDs, DOs, and ARNPs and Midwives are LIPs. Although Physician Assistants are not LIPs, they are able to provide patients with informed consent for procedures that they will perform under the sponsorship of a physician. For outpatient procedures, the consent will be valid for thirty (30) days. Signed and witnessed consent forms are valid for the duration of the signee's current hospital stay unless significant changes occur that would invalidate it. The nurse is not authorized to explain the surgery or the critical procedure. This duty lies with the LIP. The LIP must sign the consent prior to the patient being taken to the operating room.

II. Procedures that require a consent: Anything with a Code for Charges must have Informed Consent as specified by the Medical Staff. (A0392 Medical Record Procedures). Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State Law, if applicable, require written patient consent. (482.51 CMS Condition of Participation Surgical Services)

A. All procedures performed in the Surgery, Emergency department or Cardiac Catheter Lab or Interventional Radiology

B. Any patient who receives anesthesia for a procedure

C. Any patient undergoing an invasive procedure at the bedside, such as, but not limited to; Thoracentesis, Paracentesis, EEG, Chest tube or Central Line insertion, Cystoscopy, Pacemaker, Swan-Ganz insertion, PICC line, paracardiocentesis, Balloon pumps, or Arterial line insertion

D. Selected MRI and Nuclear Medicine procedures, as well as Cardiac Stress Testing

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III. The Informed Consent: The "Consent for Treatment/Procedure" will include the patient's name, the hospital's name, the physician's name and signature, the proposed procedure in lay terms and medical terms, and indications for procedure, the hospital's effort to make the consent informed (with the patient's or patient's representative initials/date), that other procedures/treatments may be indicated (with the patient's or patient's representative initials), the proposed anesthesia plan, provider name and that risks are involved (with the patient's or patient's representative initials), consent that the hospital can dispose of any substance removed during the procedure (with the patient's or patient's representative initials), consent to take/publish photos during the procedure (with the patient's or patient's representative initials). The risks, benefits and alternatives of performing the procedure will be explained to the patient. Also whether the procedure/treatment is uncommon will be discussed with the patient. The patient will be informed that they are able to change their mind about having the procedure at any time prior to the procedure, and they will need to inform a healthcare provider if they change their mind. The patient and/or patient's representative will sign the consent with date and time. The consent will be witnessed and the witness will sign consent with date and time. The consent will also include the Physician's Certification that the physician has discussed the procedure, risks, benefits, alternatives to the patient. All of these components will be included in the "Consent for Treatment/Procedure". Once signed, the "Consent for Treatment/Procedure" will be scanned and will become part of the permanent medical record.

IV. Signing the Consent: The right to make informed decisions regarding care presumes that the patient or the patient's representative has been provided information about his or her health status, diagnosis, and prognosis. Furthermore, it includes the patient's or the patient's representative's participation in the development of his/her plan of care, including providing consent to, or refusal of, medical or surgical interventions, and in planning for care after discharge from the hospital. The patient or the patient's representative will receive adequate information, provided in a manner that the patient or the patient's representative can understand, to assure that the patient or the patient's representative can effectively exercise the right to make informed decisions.

A. Is the patient lawfully able to give consent? Any patient who demonstrates competence and understanding of the medical or surgical procedure contemplated and is of age of maturity or over, may give consent to the performance of that procedure. In Kentucky, the age of maturity is 18 years. Ky. Rev. Stat. 2.015 (Supp.1971): 214.185 (Cum.Svc.Issue1971), as amended, SB# (Laws 1972). Men and women attain majority at 18 years of age for most purposes. Pursuant to Section 214.185, any emancipated minor or any minor who has contracted a lawful marriage or borne a child can give consent for hospital, medical dental or surgical care of his or her child or himself or herself; for purpose of this section only, an annulment of marriage or a divorce shall not deprive a minor of his adult status once obtained. Medical, dental, or health services may be rendered to minors of any age if the risk to life or health is such that treatment should be given without delay and the requirement of parental consent would result in delay or denial of treatment. The consent of a minor who falsely represents that he may give effective consent shall be deemed effective if service was rendered in good faith reliance upon the minor's representations. Any

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minor may consent to examination and treatment of venereal disease, pregnancy, alcohol or other drug abuse or addiction.

B. Unmarried minors normally may not give consent to medical and surgical procedures. In such case, the parent or someone standing in legal place of the parent must give the consent.

C. Married minors and minors under the age of 18 may give consent in certain circumstances. A married minor may also give consent for his or her child.

D. Kentucky State Law (KRS 212.347) requires that consent for elective sterilization be obtained at least 24 hours prior to the performance of the procedure.

E. Patients who are unconscious or otherwise not competent or in command of their mental faculties cannot give a binding consent. In such cases, consent must be obtained from someone authorized to consent for the patient, or the procedure must be classed as a life threatening emergency. In the event that the patient is at risk for losing his/her life or limb, the Consent will be waived. But all efforts will be made to explain the procedure to the patient and/or family to inform them of the proposed procedure/treatment and its implications. The physician will be responsible for determining if there is time to secure the consent. The physician and nurse will document in the medical record that the consent was waived and the reason consent was not obtained.

F. A LIP obtaining informed consent is responsible for determining whether their patient's or patient's lawfully authorized representative's preferred language is English. If the preferred language is not English, all consent discussions must take place in the language of preference of the patients or lawfully authorized representative with the assistance of an interpreter. Whenever possible, a professionally trained interpreter should be used.

G. When patients have other communication barriers the LIP should arrange for consent discussions to take place using a communication modality in which the patient is fluent. For the blind, a verbal translation in the appropriate language is normally sufficient. For the deaf, written communication or sign language through a professionally trained medical interpreter may be used. A deaf person may indicate that they require a sign language interpreter and they should be given the same consideration as a patient with limited English proficiency. Other handicap manifestations such as muteness should be dealt with appropriately.

H. It should be noted that all consents to be binding must be obtained prior to the administration of pre-operative sedation of anesthesia.

I. The consent must be signed prior to the patient being taken to the operating room. The consent Form will be used during the Time-Out procedure.

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J. Whenever a consent form is signed in a physician's office, or outside the Medical Center, the consent will be included in the patient's medical record and will be valid as long as the informed consent process has been followed and the consent form is accurate and complete.

V. Witnessing the Consent: The consent must be witnessed by a healthcare provider and may deliver the form to the patient for his/her signature in order to witness the signing of the consent form. By securing the signature, the staff member is only witnessing that the signature is that of the purported patient or legal guardian, and that the signer is alert and lucid. If the patient/guardian states he does not understand, or has questions regarding the nature of the procedure, the staff will notify the physician. The staff member will not proceed with witnessing the signature until the patient is provided further explanation by the physician.

References:

Revision Summary:

Revision Date	Responsible Person	Description of Revision
01/28/2014	Deanna Rice, RN	New Format only

Attachments:

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Highlands Regional Medical Center

Policies and Procedures

Subject:	Informed Risks, Benefits, Side Effects of Medications & Treatments Policy#: 03.15.03	Department: 3A
Scope:	Behavioral Health Unit	Original Policy Date: 03/2003
Regulatory Standard:	Highlands Policy: Guidelines for Policies and Procedures DNV: PR.1-, SR.2, SR.3, PR.4	Revision Date: 3/2007, 3/2011, 8/2012, 01/2014
Location of Signed Original:	Administration	Page: 1 of 2

Author: Bruce Fletcher, RN Clinical Manager 1/30/14
 Signature & Date
Approval Signature: Sherri Shaw 1-31-14
 Signature & Date
Approval Signature: Susan Ellis, RN VP Patient Care Services 1/31/14
 Signature & Date
Approval Signature: _____
 Typed Name and Title of Individual Approving Policy Signature & Date

PURPOSE

To provide a procedure for informing patients about the Patient's Bill of Rights.

POLICY

The Behavioral Health unit shall obtain an informed written consent from each patient or authorized representative for the provision behavioral and/or medical care except in behavioral and medical emergencies. The consent shall include an explanation of the risks, benefits, and alternatives for high risk procedure and sedation as defined by the medical staff and State Law.

Each patient has the right to explanation of the care, procedures, and treatment that are prescribed. This right extends to the legal guardian of the person when applicable, and to any other person authorized by the individual served.

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PROCEDURE

- I. Provide each patient, family member or guardian a copy and explanation of the Patient's Bill of Rights upon admission to the unit.
- II. The patient shall be provided an explanation of care, procedures, and treatment to be provided including:
 - A. Risks, side effects, and benefits of all medications and treatment procedures to be used, including those that are unusual or experimental
 - B. Alternative treatment procedures that are available
 - C. Possible consequences of refusing treatment or procedure
 - D. The right to refuse or revoke consent for treatment
- III. Document such explanation in the patient's medical record.
- IV. Obtain written informed consent, when required, for procedures and treatments, i.e., consent for all psychotropic medication is required.

❖ Refer to HRMC Admissions Policy and Procedure Manual for Detailed Patient Rights

References:

Revision Summary:

Revision Date	Responsible Person	Description of Revision
1/2014	Bruce Fletcher, RN	Revision to new word format.

Attachments:

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Audit Performed by: _____

BH11

Weekly audit on your unit. A total of 5 audits should be performed. Audits should be include the items listed below

Item	Date														
(Patient Interview) the nurse and Patient/POA/Guardian have discussed the patients current condition and need to start, continue or change psychotropic medications	FIN #														
(Observation) The patient is exhibiting appropriate behavior or controlled behavior with psychotropic medications															
(Chart Review) Documentation present on the education provided about the new psychotropic medication															
(Observation) Consent completed for new Psychotropic medication or documentation present indicating guardian notified of medication change															
Documentation of previous behaviors before starting or changing medications present.															
Patients level of consciousness is addressed in documentation and is monitored, with any changes IMMEDIATELY reported to physician.															
Patient/ guardian feels well informed concerning medication administration/changes															

Ex 616, 442

Exhibit 43



MEMO

March 26, 2014.

BHI STAFF:

The documentation process has been changed from the BIRP (Behavior, Interventions, response and Plan) format to a Descriptive Note. The RN will make an entry into the patients shift note at least every two hours. This is to provide a more thorough documentation of observation and patient reassessment every two hours. The note will continue to follow a patient's treatment plan and will address any changes made to the plan of care.

The Policy and Procedure for Patient Documentation has been updated to reflect this change.

Bruce M. Fletcher, R.N

Behavioral Health Progress Note

* Final Report *

Result Type: Behavioral Health Progress Note
Result date: April 02, 2014 07:33 EDT
Result Status: Auth (Verified)
Result Title: shift assessment
Performed By: Shepherd, Grace RN on April 02, 2014 07:36 EDT
Verified By: Shepherd, Grace RN on April 02, 2014 18:08 EDT
Encounter info: 2932621, Behav Health IP, Geropsych, 04/01/14 -

* Final Report *

dx-generalized anxiety disorder nos bipolar disorder nos.

0700-supine in bed,bed in low position with side rails up x2.bed alarm on ,water pitcher in reach.alert to name only.smiles when interacting with nurse.iv to left forearm with 0.95 normal saline @ 75ml/hr.

0900-lying in bed on right side.pleasant when talking with staff.fall precautions in place.

1100-lying in bed on left side.awake.denies any pain or discomfort.bed in low position with side rails up x2.bed alarm in place.

1300-pt sitting on side of bed.pleasant and cooperative with staff.no aggression or agitation.fall precautions in place,bed low,side rails up x2.bed alarm in place.

1500-lying in her bed looking out the window.blunted affect.pleasant.fearful of falling when turned.no agitation or aggression.fall precautions in place.

1700-pt pleasant and cooperative.no agitation or aggression.falll precautions in place.

Completed Action List:

- * Perform by Shepherd, Grace RN on April 02, 2014 07:36 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 10:06 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 10:06 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 11:16 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 11:16 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 13:02 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 13:03 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 13:03 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 15:31 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 15:31 EDT
- * Sign by Shepherd, Grace RN on April 02, 2014 18:08 EDT Requested by Shepherd, Grace RN on April 02, 2014 18:08 EDT
- * Modify by Shepherd, Grace RN on April 02, 2014 18:08 EDT
- * VERIFY by Shepherd, Grace RN on April 02, 2014 18:08 EDT

Highlands Regional Medical Center

Policies and Procedures

Subject:	Patient Charting	Policy#: 02.09.01	Department: 3A
Scope:	Behavioral Health Unit		Original Policy Date: 03/2003
Regulatory Standard:	Highlands Policy: Guidelines for Policies and Procedures DNV:MR.2-SR.3; MR.4-SR.1, MR.5-SR.1 a-c, SR.2 a & b, SR.3, SR.4, SR5 (1) (2) (3); Mar.6; MR.7-SR.1 a & b, SR2 through SR.8		Revision Date: 3/2007, 3/2011, 8/2012, 01/2014, 4/2014
Location of Signed Original:	Administration		Page: 1 of 4

Author: _____
Bruce Fletcher, RN Clinical Manager Signature & Date

Approval Signature: _____
Sherri Shaw, Regional Director UltraGroup Healthcare Signature & Date

Approval Signature: _____
Susan Ellis, RN VP Patient Care Services Signature & Date

Approval Signature: _____
Typed Name and Title of Individual Approving Policy Signature & Date

PURPOSE

Proper patient charting helps to ensure continuity of care, provides the necessary information for further evaluation of patient care, and is necessary for proper billing to third-party payers.

POLICY

Each patient shall have a separate hospital record to provide an accurate record of progress, to use as a reference for continuity of care, and to use as a guide to further evaluate patient care. The charting shall contain information to:

1. Justify admission and continued hospitalization.
2. Support the diagnosis.
3. Describe the patient's status at the time of admission to include but not limited to:
 - Patient's condition at admission and discharge.

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- Patient's progress throughout course of treatment.
- Patient's response to medication and treatment plan.
- 4. Reflect chronological picture of the patient's clinical course.
- 5. Reflect all treatment rendered to the patient.
- 6. Reflect the implementation of the treatment plan.
- 7. Describe any changes in the patient's condition.
- 8. Describe responses to and outcome of treatment.
- 9. Describe the discharge process and continuing care planning, and need for additional treatment.

PROCEDURE

- I. Record all notations legibly, accurately, and concisely in black ink on all written documents; only approved abbreviations may be utilized (see Hospital Policy & Procedures).
- II. Record exact time of the charted occurrence for each notation. Incidents requiring specific follow-up are to be charted to include specific times of each follow-up action and patient's response. All unusual events will be charged.
- III. Identify all notations with signature and credentials of recorder. Title should be indicated on form.
- IV. Content of charting should either be direct quotes of the patient or specific facts that have been observed. The nurse will document the patient's improved behavior and/or treatment response based upon their individualized nursing treatment plan. The source oriented or narrative style format of documentation is to be followed.
- V. As Continuing Care Planning is implemented (i.e., related conferences with patient, family and continuing care resources or placement, and pre-discharge visits), the therapist shall document the occurrence and significant responses of the patient's family, etc. in the EMR.
- VI. Last names of other patients or staff members are not to be recorded (only initials or first name and last initial.).
- VII. A line should be drawn between the last word of a note and signature to fill an empty space on that line (on any written documents). Never leave blank spaces or lines. Do not skip spaces to accommodate missed entries by other personnel.
- VIII. Correct errors by drawing one single line through the erroneous statement and note "error" and add initials above the line. **DO NOT ERASE! DO NOT USE CORRECTON FLUID!**

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- IX. Stamp all paper form pages with the addressograph plate in the lower right corner. (May use the organization's set standards of patient chart identification).**
- X. Information should reflect, but is not limited to the following:**
- a. Observation of the patient's status and responses in the course of therapeutic contact.
 - b. Patient's response to treatment as it relates to the individualized active treatment goals.
 - c. Clinical notes are part of the medical record and cannot be removed from the facility.
- XI. Chart entries should be entered daily for each billable entry. Information should reflect, but is not limited to the following:**
- a. Entries should be made on the same date of service. If the entry is not completed on the date of service provided, it is considered and should be noted as a "Late Entry." A pattern of late entries are considered a red flag and can result in focused medical review.
 - b. The nursing staff shall chart a minimum of once per shift in the form of a shift summary.
 - c. All therapists shall chart after each individual or group therapy intervention.
 - d. Nursing will chart all medication and nutrition teaching groups in the Education Form in the EMR CERNER.
 - e. The other ancillary therapist shall chart either for each rendered service or on a daily note.
 - f. Family Therapy sessions will be charted in Cerner under the appropriate heading ("Other" or "Discharge Planning").
 - g. Contacts concerning patients discharge or aftercare will be charted on the Summary Notes page under Discharge Planning.
- XII. All identified problems on the Master Treatment Plan shall be addressed by number on the Interdisciplinary Progress Notes with charting to reflect patient's behavior, your intervention, patient's response to your intervention, and your plan for reinforcing, redirecting, or addressing the patient's behavior. Effectiveness of plans of care is demonstrated with continuing implementation of changes or revisions which are documented. Each entry must be signed with the appropriate credentials (NOT job title).**

References:

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Revision Summary:

Revision Date	Responsible Person	Description of Revision
1/2014	Bruce Fletcher, RN	Revision to new word format.
4/2014	Bruce Fletcher, RN	Revised documentation format from BIRP to source oriented or narrative style. (Procedure IV)

Attachments:

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Exhibit 44

HIGHLANDS REGIONAL MEDICAL CENTER
Behavioral Health In-service Roster

Date: March 17, 2014

Clinical Manager: **Bruce Fletcher**

Unit: **3A**

Subject: **Staff Education and Unit Monitoring Changes**

Name	Date	Int.	Name	Date	Int.
Sherry Ray	3/17/14	BK	Jennifer Music	3/18/14	JM
Anthonea Halfhill	3-17-14	A4	Bront Slone	3-26	BS
Melinda Deerfield	3-17-14	MS	Shelby York	3-18-14	SY
			Jessica Lafferty	3/18/14	JL
Betty Martin	3-17-14	BT	Jennifer Akers	FMLA	
Anna Dye	3-17-14	AD	Ella Newman	3/20/14	EN
Melissa Caudill	3/20/14	MC			
Sheila Gambil	3-17	SG	Carrie Caudill	PRN	
Grace Shepherd	3/19	GS	Mary Jarvis	3/3	MJ
Trish Hinkle	3/19	TH			
Ruby Watkins	3/19	RW			
Charlene Horn	FMLA				

MLOA

Sign below to indicate you read the minutes and materials from the staff meeting but were unable to attend.

A Copy of this sheet is kept in staff meeting log for employees to sign.



Behavioral Health Services at
HIGHLANDS
Behavioral Health Services at Highlands Regional
R E G I O N A L
The Medical Center of Eastern Kentucky.

3-17-2014

Monitoring changes that have taken effect:

Notice: To improve patient care a new protocol is in effect.

Patients are not to be sitting in a chair for more than two hours:

During that time patient's weight is to be shifted from side to side every hour and this is to be documented in Cerner. After two hours patient will be ambulated with assistance or returned to bed.

HIGHLANDS REGIONAL MEDICAL CENTER
 Behavioral Health In-service Roster

Date: April 1, 2014

Clinical Manager: **Bruce Fletcher** Unit: **3A**

Subject: **Changing of Vital Signs to every 4 Hours**

Name	Date	Int.	Name	Date	Int.
Sherry Ray	4/1/14	SR	Jennifer Music	4-1-14	JM
Anthonea Halfhill	4-1-14	AL	Brent Stone	4-3-14	DS
Melinda Deerfield	4-1-14	MB	Shelby York	4-1-14	SY
			Jessica Lafferty	4/1/14	SL
Betty Martin			Jennifer Akers		
Anna Dye	4/1/14	AD	Ella Newman	4/2/14	EN
Melissa Caudill	4-1-14	MC			
Sheila Gambil	4-1-14	SG	Carrie Caudill		
Grace Shepherd	4/2/14	GS	Mary Jarvis		
Trish Hinkle	4/2/14	PH			
Ruby Watkins					
Charlene Horn					

Sign below to indicate you read the minutes and materials from the staff meeting but were unable to attend.

A Copy of this sheet is kept in staff meeting log for employees to sign.



4/1/2014

Patients will now have Vital Signs completed every 4 hours (0700, 1100, 1500, 1900, 2300 & 0300). With the exception of midnight shift and it will be every 4 hours while awake. With the population we serve, this will aid in the earliest detection of any Health issues that may arise. The vital sign selection of the Admit Behavioral Health Care Set has been changed to aid in the ordering of this task.

Bruce

BHI Training Objectives

- I. Justification of Psychotropic Medications, uses, and side effects to watch for.**
- II. Using the Pneumonic DELIRIUM to assess the underlying causes of delirium**
- III. How to use the (CAM) Confusion Assessment Method to assess altered mental status due to delirium**
- IV. Comparison of the clinical features of Delirium, Dementia, and Depression**
- V. Case study on assessing level of consciousness with a competency exam to see how well everyone is understating information being presented**

Identify Underlying Medical Conditions

**Ladonna Chirpas
Jerrina Gusler**

Identification

- Multifactorial
- Use Pneumonic: **DELIRIUM** to assess for underlying contributing factors causing delirium
 - **D**elirium
 - **E**-Electrolyte
 - **L**ow Oxygen
 - **I**nfection
 - **R**-Reduced sensory input
 - **I**ntoxication
 - **U**riinary or fecal retention
 - **M**etabolic

Woods & Horda, 2011

D-E-L-I-R-I-U-M

• Drugs

- Review drug lists
- Check for therapeutic levels
- Note recent additions/omissions
- Effects of dehydration or sepsis on metabolism
- Old age change in metabolism of meds

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D-E-L-I-R-I-U-M

• Electrolyte

• Lab work - Flag abnormalities

• Sodium

• Potassium

• BUN

• Creatinine

• Calcium

• Glucose

• Dehydration?

• Urine specific gravity

• Urine color

© Melillo & Moore, 2013

D-E-L-I-R-I-U-M

o low Oxygen States

- Myocardial Infarction
- Stroke
- Pneumonia

o O₂ saturation

(Means & Meade, 2001)

D-E-L-I-R-I-U-M

o Infection

o ** UTI

- ** common cause of change in mental status

o Pneumonia

- Altered mental status could be primary symptom as older adults often lack common symptomatology

o Labwork

- Elevated WBC may indicate these and other infections

(Wheeler & Ritchie, 2011)

D-E-L-I-R-I-U-M

o Reduced Sensory Input

- Glasses
- Hearing aids
- Environmental
 - Understimulating
 - Overstimulating
 - Recent changes in environment or hospital unit
- Orientation Cues
 - Calendar
 - Clock

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D-E-L-I-R-I-U-M

o Intracranial

- Cerebrovascular accident - CVA
- Transient Ischemic Attack - TIA
- Seizure
- Subdural hematoma
 - Recent fall
- Neuro assessment
 - Neuro work up may be needed

Malik & Hodge, 2011

D-E-L-I-R-I-U-M

• Urinary or Fecal Retention

• Abdominal Assessment

• Review I&O records

© Malloy & Brady, 2010

Confusion Assessment Method

A tool to assess altered mental status due to delirium

1. Acute onset and fluctuating course

Is there evidence of an acute change in mental status from baseline?

Did the clinician observe fluctuating attention over the day, tend to come and go, or increase and decrease in severity?

2. Inattention

Did the patient have difficulty focusing attention?

Is he/she easily distractible or having difficulty keeping track of what was being said?

3. Disorganized Thinking

Was the patient's thinking disorganized or incoherent?

Is there a gross level of conversation, unclear or illogical flow of ideas, inappropriate switching from subject to subject?

4. Altered Level of Consciousness

Normal alert hyper-alert, delirium, drowsy, easily aroused, lethargic, difficult to arouse, stupor, unconscious, coma

(Melillo & Houde, 2011)

Confusion Assessment Method CAM

Yes answers on items 1-3 = positive indication of
Feature #'s 1-3.

Any answer except Alert = positive indication for
Feature #4

Delirium is noted by CAM by these results

+ Features 1 and 2

and

+ Feature either 3 or 4

(with the exception of 4)

Comparison of the Clinical Features of Delirium, Dementia, and Depression

Clinical Feature	Delirium	Dementia	Depression
Onset	Acute/Subacute, depends on cause, often at twilight or in darkness	Chronic, generally insidious, depends on cause	Coincides with major life changes, often abrupt
Course	Short, diurnal fluctuations in s/s, worse at night, in darkness and on awakening	Long, no diurnal effects, s/s progressive yet relatively stable over time	Diurnal effects, typically worse in the morning, situational fluctuations, but less than with delirium

(Melillo & Houde, 2011)

Comparison of the Clinical Features of Delirium, Dementia, and Depression

Clinical Feature	Delirium	Dementia	Depression
Orientation	Generally impaired, severity varies	Generally normal	Selective disorientation
Memory	Recent and immediate impaired	Recent and remote impaired	Selective or "patchy" impairment "islands" of intact memory
Thinking	Disorganized, distorted, fragmented, incoherent speech, either slow or accelerated	Difficulty with abstraction, thoughts impoverished, judgment impaired, words difficult to find	Intact but with themes of hopelessness, helplessness, or self-deprecation

(Munich & Honig, 2011)

Comparison of the Clinical Features of Delirium, Dementia, and Depression

Clinical Feature	Delirium	Dementia	Depression
Perception	Distorted, illusions, delusions, and hallucinations, difficulty distinguishing between reality and misperceptions	Misperceptions usually absent	Intact, delusions and hallucinations absent except in severe cases
Psychomotor Bx	variable, hypokinetic, hyperkinetic, and mixed	Normal may have apraxia	Variable, psychomotor retardation or agitation

(Meillo & Houde, 2011)

Comparison of the Clinical Features Cont.

Clinical Feature	Delirium	Dementia	Depression
Sleep-Wake cycle	Disturbed cycle reversed	Fragmented	Disturbed, usually early morning awakening
Associated features	Variable, affective changes, s/s autonomic hyperarousal, exaggeration of personality type, associated with acute physical illness	Affect tends to be superficial, inappropriate and labile, attempts to conceal deficits in intellect, personality changes, aphasia, agnosia may be present, lacks insight	Affect depressed, dysphoric mood, exaggerated and detailed complaints, preoccupied with personal thoughts, insight present, verbal elaboration

(Muller & Houde, 2011)

Comparison of the Clinical Features of Delirium, Dementia, and Depression

Clinical Feature	Delirium	Dementia	Depression
Assessment	Distracted from task, numerous errors	Failings highlighted by family, frequent "near miss" answers, struggles with test, great effort to find an appropriate reply, frequent requests for feedback on performance	Failings highlighted by individual, frequently answers "I don't know", little effort, frequently gives up, indifferent toward test, does not care or attempt to find answer

(Mullis & Honde, 2011)

References

- Melillo, E., & Houde, S. (2011).
Geropsychiatric and mental health
nursing. (2nd ed.). Sudbury, MA: Jones
& Bartlett Learning.

Comparison of the Clinical Features of Delirium, Dementia, and Depression

	Delirium	Dementia	Depression
Onset	Acute/Subacute, depends on cause, often at twilight or in darkness	Chronic, generally insidious, depends on cause	Correlates with major life changes, often abrupt
Course	Short, diurnal fluctuations in s/s; worse at night, in darkness and on awakening	Long, no diurnal effects; s/s progressive yet relatively stable over time	Diurnal effects typically worse in the morning; situational fluctuations, but less than with delirium
Orientation	Generally impaired; severity varies	Generally normal	Selective disorientation

(Mejillo & Houde, 2011)

Comparison of the Clinical Features of Delirium, Dementia, and Depression

Memory	Recent and immediate impaired	Recent and remote impaired	Selective or "patchy" impairment "islands" of intact memory
Thinking	Disorganized, distorted, fragmented, incoherent speech, either slow or accelerated	Difficulty with abstraction, thoughts impoverished, judgment impaired, words difficult to find	Intact but with themes of hopelessness, helplessness, or self-deprecation
Perception	Distorted, illusions, delusions, and hallucinations, difficulty distinguishing between reality and misperceptions	Misperceptions, usually absent	Intact, delusions and hallucinations absent except in severe cases
Psychomotor: dx	variable, hypokinetic, hyperkinetic, and mixed	Normal may have apraxia	Variable, psychomotor retardation or agitation

(Mellillo & Houde, 2011)