



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

PRINTED: 01/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2013
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NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078
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F 000	INITIAL COMMENTS	F 000	The statements contained in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined, the facility failed to ensure one resident (#1,) in the select sample of five residents, was supplied the proper respiratory equipment to ensure adequate oxygenation, at the facility and on trips to the physician's office. Findings Include: Record review revealed Resident #1 was admitted on 11/09/12, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and Cognitive and Communication Deficits. A review of the quarterly Minimum Data Set (MDS)	F 328	1. Resident #1 was provided a portable oxygen tank that he preferred 1/22/13. 2. Residents using portable oxygen tanks have the potential to be affected. 3. DON or designee will evaluate via interview of residents on oxygen within 48 hours of admission or a new order. Current residents on oxygen interviewed on their preference of oxygen delivery. DON educated nursing staff on need for interviewing residents on oxygen within 48 hours of admission or new order completed. 4. Compliance for this process will be monitored on each new admission or for residents with a new order for oxygen by the Administrator, DON, and or designee within 72 hours. Monitoring will continue indefinitely until deemed proficient by Continuous Quality Improvement committee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jimmy Workman TITLE: Administrator (X6) DATE: 2/8/13

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

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F 328	<p>Continued From page 1</p> <p>assessment, dated 01/01/13, revealed the resident scored eight (8,) out of 15, on the Brief Interview for Mental Status (BIMS,) which indicated the resident needed assistance with cognition, in new situations. The facility assessed Resident #1 as independent with bed mobility and needing supervision and set up assistance for transfers and ambulation, always continent of bowel and frequently incontinent of bladder. The resident was noted to experience shortness of breath with the exertion experienced with walking, transferring and bathing and required the use of oxygen (O2.) A review of the resident's care plan for Self Care Deficit related to COPD, dated 11/09/12, revealed the resident "could be up, as tolerated, with a cane and oxygen" and the staff were to "encourage frequent breaks." A review of the "Clinical Respiratory Monitoring" Form, dated November 2012, revealed the resident's O2 saturations were averaging 92-95% and were taken every shift.</p> <p>An observation of Resident #1, on 01/16/13 at 11:25 AM, revealed the resident independently ambulated down the hallway, approximately 75 feet, to the resident's room, utilizing a seated walker and a portable O2 tank at two (2) liters per nasal canula. While transferring to the bed and changing from the portable O2 to the O2 concentrator, the resident experienced shortness of breath with respirations of 32 breaths per minute (b/m) and an O2 saturation of 76 percent (%.) After application of the concentrator's O2 and nasal cannula, at two (2) liters and staff encouraging the resident to "breathe deeply through his/her nostrils, the O2 saturation increased to 90% and respirations decreased to 24 b/m, taking approximately five minutes for the</p>	F 328	<p>5. Findings will be discussed in morning clinical meeting for compliance by the Administrator or designee and reported in the monthly Continuous Quality Improvement meeting.</p>	1/26/13

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F 328	<p>Continued From page 2 O2 saturallon to Increase.</p> <p>An interview with Resident #1, on 01/15/13 at 2:15 PM, revealed the resident was not pleased with the portable O2 tanks, as he/she had used a large cylinder, pulled on a rolling apparatus, "for years at home and this thing will choke you to death, trying to get air out of it," speaking of the small portable unit that had a strap to go over the shoulder. The resident asked to have a portable cylinder and was told, by "several nurses" they only carried the one he/she was using."</p> <p>An interview with Resident #1's family member, on 01/14/13 at 4:00 PM, revealed the family member stated the portables were known to leak and don't hold as much volume as the resident had been used to and could have gone all day, without needing a refill, on the cylinder tank the resident had at home. There were no problems with the concentrator in the room, when the resident stayed close to the bed, just when he/she wanted to go to the bathroom or down the hall to visit others and had to use the portables or had to leave the facility for a physician appointments. The resident did not see well and the family member felt the resident could have incorrectly set the gauge higher than 2 liters or possibly may have not turned the unit totally off when he/she changed back to the room concentrator, however, neither the family member or the resident were pleased with the portable unit.</p> <p>An interview with Registered Nurse (RN) #1, on 01/16/13 at 3:15 PM, revealed the resident's O2 saturation was taken every shift, or with complaints of shortness of breath or with exertion</p>	F 328			

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F 328	<p>Continued From page 3</p> <p>and normally stayed above 90% and stated the resident "fidgets" with the portable unit, but the RN had not seen the resident's O2 saturation "that low." She also stated, with the resident's long history of COPD, there really wasn't much they could do but to encourage the resident to breath deeply, through the nose and try and slow his/her breathing when anxious and short of breath. The RN stated she had spoken to both of the resident's physicians, who stated they did not want the O2 above two (2) liters, for this resident, as this could harm the lung, but the resident did have an order for nebulizer treatments that can be done, as needed, for shortness of breath. The RN was aware of the resident's concerns with the portable unit and of wanting one like he/she had used at home. However, the RN stated those units were the only type that were supplied at the facility but had never asked anyone if the supplier could make another type available that the resident may trust more than the current model.</p> <p>An interview with the physician, on 01/16/13 at 4:15 PM, revealed he did not want Resident #1's oxygen raised higher than two (2) liters due to a long and chronic use of oxygen and history of COPD and stated the resident was Carbon Dioxide (CO2) dependent, not O2 dependent, as respirations in this type of resident were driven by CO2. An increase in O2 would suppress or decrease the resident's respirations and could stop the resident's breathing, altogether. The physician was aware of the resident's complaints of "smothering" on the portable tank but the O2 saturation and oxygenation was acceptable, when the physician had seen the resident in his office and stated his/her concerns could be due to some anxiety and dislike for the type of portable</p>	F 328			

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F 328	<p>Continued From page 4</p> <p>equipment. The physician was accepting of trying another type of portable tank, if this would put the resident, "at ease," but the physician had not been asked about a different type of portable concentrator before.</p> <p>An interview with the Director of Nursing (DON,) on 01/16/13 at 5:00 PM, revealed the portable O2 tanks were the only ones available at the facility, despite the company brochure listing several tanks to choose from. She stated she did not like the tank either, when the facility first started using them six years ago but the staff were "getting used to them." She was aware Resident #1 preferred the one used at home, called the "Big E Tank," but had not tried to obtain this from the supplier and stated the staff have tried to educate the resident and the family members and had shown them how to use the portable tanks, several times.</p> <p>An interview with the Administrator, on 01/16/13 at 5:20 PM, revealed the Administrator had not been made aware Resident #1 was not satisfied with the operation of the portable O2 tanks. There had been no discussion about finding a more acceptable portable concentrator and stated, "if that's what he/she needs, we will get it."</p>	F 328		