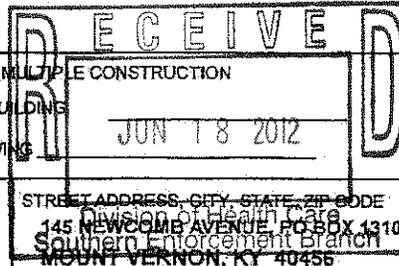


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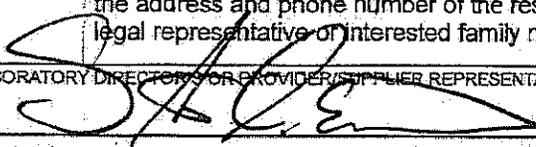


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185157	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/24/2012
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NAME OF PROVIDER OR SUPPLIER ROCKCASTLE REGIONAL HOSPITAL AND RESPIRATORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 145 NEWCOMB AVENUE, PO BOX 4310 MOUNT VERNON, KY 40455
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY18362) was conducted on 05/24/12. The allegation was substantiated. Deficient practice was identified at 'D' level.	F 000	Resident #1's guardian was contacted by the unit coordinator, social services and the physician and advised of status, reviewed plan of care; care being provided to resident and rationale for care changes. Completion Date: May 15, 2012	7/02/12
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	All residents have potential to be affected by failure to call legal representative immediately. The Unit Coordinators reviewed current residents for timeliness of notification of significant changes. Information obtained from the review was utilized to develop education packet and shared with nursing staff. Completion Date: May 21, 2012 CNO published memo to all RCC nursing units related to the policy "Notification of Resident Changes". Nursing staff documented by signature acknowledgement of memo review. Completion Date: May 22, 2012 "Notification of Resident Changes" Policy was reviewed. Completion Date May 18, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **CEO** (X6) DATE **6/18/12**

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy/procedure review, it was determined the facility failed to immediately inform the resident's legal representative when there were significant changes in physical status for one of three sampled residents (Resident #3). On 05/09/12, at 7:00 AM, Resident #1 was found unresponsive and facility staff provided assisted ventilation with use of an Ambu Bag (a medical device used to provide assisted ventilation to people who are either not breathing or are having trouble breathing), however, Resident #1's guardian was not notified of the incident until 05/09/12, at 5:57 PM, a timeframe of ten hours and fifty-seven minutes after the incident. On 05/11/12, at 2:45 AM, Resident #1 complained of lower abdominal pain and was assessed to have "critical" vital signs. Resident #1 again required respirations be provided via Ambu bag, however, Resident #1's guardian was not notified of the incident until 05/11/12, at 11:15 AM, eight hours and thirty minutes after the incident. The findings include: A review of facility policy, "Notification of Changes in Resident Status," revised September 2010, revealed the facility would immediately notify the legal representative of a change in the resident's physical status, deterioration in health, or a need to alter treatment significantly. A review of Resident #1's medical record revealed the facility admitted the resident on:	F 157	Self-learning packet was developed and distributed on "Notification of Resident Changes". The Education included a copy of policy; additional examples of when to notify residents' legal representative including importance of timely notification and processes for contacting legal representative if the primary nurse is occupied providing care for the resident. Nurses completed an exam and returned to unit coordinator. This information was added to the individual employee education competency file. Completion Date: June 8, 2012 The self-learning packet education on "Notification of Resident Changes" has been incorporated into orientation for new nursing employees. This information has also been added as part of the resident rights education that employees complete as part of annual training. Completion date: June 23, 2012 RCC Charge nurse meeting was held on May 24, 2012. Agenda item included timely notification of changes in resident conditions. CNO gave overview of recent review, discussed policy and clarified who and when to report. Opportunities		

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F 157	<p>Continued From page 2</p> <p>11/12/93, with diagnoses to include Ventilator Dependency. A review of Resident #1's Comprehensive Care Plan created 11/02/07 revealed staff had identified an objective to reinforce and maintain the resident's family support by implementing interventions which included discussing any concerns, thoughts, or feelings family members may have regarding resident care. A review of Resident #1's Minimum Data Set assessment dated 04/18/12, revealed Resident #1 was totally dependent on staff for assistance with all Activities of Daily Living.</p> <p>A review of nursing notes revealed on 05/09/12, at 7:00 AM, Resident #1 experienced an episode of unresponsiveness and the facility's "rapid response team" was utilized. Resident #1 required respirations be administered via Ambu bag. The physician was notified and orders were received for further tests to be obtained.</p> <p>Resident #1's nursing notes revealed on 05/09/12, at 5:53 PM, the resident's guardian was notified of the "resident's respiratory episode this AM." An interview conducted on 05/24/12, at 2:30 PM, with Registered Nurse (RN) #1 revealed she waited to notify Resident #1's guardian for approximately eleven hours after the incident had occurred, because she was waiting for all the test results which had been ordered to be available so she could report those results to the guardian. RN #1 stated in the interview that Resident #1's guardian became upset and voiced concern at not being notified earlier of the incident. RN #1 stated she assured the guardian "it would not happen again." However, RN #1 stated she did not forward Resident #1's concerns or notify</p>	F 157	<p>were provided for questions, answers and education. Completion date: May 24, 2012</p> <p>CNO provided information at LTC Medical Staff meeting regarding review, deficiency and action taken to improve timeliness of reporting changes in resident conditions to legal representatives. Completion date: May 22, 2012</p> <p>Education sheet regarding importance of communicating resident or legal representative concerns to appropriate disciplines and or administration will be distributed to all nursing staff for review and acknowledgement. Completion Date: June 23, 2012</p> <p>Report Sheet was update to include documentation of notification of changes in condition. Completion: June 23, 2012</p> <p>To monitor for compliance, the unit coordinators will do weekly random review of the report sheets to identify residents with significant changes. The unit coordinators will then assess the medical record to identify if the legal representative was notified in a</p>		

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F 157	<p>Continued From page 3</p> <p>Administration or Social Services that the guardian had voiced concern or was upset at not being notified timely when Resident #1 experienced a change in condition.</p> <p>Further review of nurse's notes for Resident #1 dated 05/11/12, at 4:00 AM, revealed the resident complained of abdominal pain and shortness of air. The resident was assessed to have an increased heart rate of 124, and blood pressure of 204/109. Resident #1 was also assessed to have decreased oxygen saturation, and respirations were administered via Ambu bag. Resident #1's physician was notified and orders were obtained for medications and further tests. However, Resident #1's nurse's notes indicated the guardian was not notified of the episode until 05/11/12, at 11:15 AM (eight hours and thirty minutes later). An interview was conducted on 05/24/12, at 4:20 PM, with RN #2, who was caring for Resident #1 on 05/11/12, during the resident's change in condition. RN #2 stated she did not call Resident #1's guardian at the time of the incident, because she "did not know" Resident #1's family member was "involved" in the resident's care and had assumed the resident was a "ward of the state."</p> <p>An interview was conducted on 05/24/12, at 3:10 PM, with RN #3, who had contacted Resident #1's guardian on 05/11/12, at 11:15 AM. RN #3 stated she called the guardian to obtain consent for medical procedures ordered by the resident's physician as a result of the "incident" which had occurred earlier that morning. RN #3 stated the guardian's immediate response when contacted was "what incident." RN #3 stated the guardian had not been notified of the resident's change in</p>	F 157	<p>timely manner. This review will be incorporated into the organizational performance improvement program and monitored for continued compliance.</p> <p>Effective July 1, 2012</p>	
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F 157	Continued From page 4. condition prior, was very upset, and requested to speak to Social Services. An interview was conducted on 05/24/12, at 3:00 PM, with the Social Worker who spoke to Resident #1's guardian on 05/11/12. The Social Worker stated she immediately notified the Director of Nursing (DON) of the guardian's concerns. An interview was conducted on 05/11/12, at 4:00 PM, with the DON who stated she had been unaware that Resident #1's guardian had voiced any concerns regarding timely notification of resident changes prior to 05/11/12.	F 157			