

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

2nd SOD

PRINTED: 12/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	<div style="border: 2px solid black; padding: 5px; display: inline-block;"> RECEIVED (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING <u>7</u> 2013 Division of Health Care Enforcement Southern Branch ELKHORN CITY, KY 41522 </div>		(X3) DATE SURVEY COMPLETED C 10/29/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522		
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY20865) was initiated on 10/22/13 and concluded on 10/29/13. The complaint was unsubstantiated; however, deficient practice was identified at "G" level, with an opportunity to correct, related to the staff's failure to assess and notify the physician of a change in condition for Resident #1.</p> <p>Resident #1 returned from the hospital on 10/07/13 at 11:30 AM, and staff observed Resident #1 to yell out with repositioning and care and noted the resident had a bruise to the rib area. The nurse was notified but failed to notify the physician. On 10/08/13 at approximately 10:00 AM, and again at 3:00 PM, staff observed Resident #1 in bed with his/her right arm positioned under his/her back; the resident was not able to move his/her right arm and complained of pain when staff attempted to move his/her right arm. Staff informed Licensed Practical Nurse #1 of the change in Resident #1's condition but the physician was not notified. On 10/09/13 at 7:15 AM staff observed bruising to Resident #1's right shoulder, scapula (shoulder blade), and the auxiliary (armpit) area, and the resident had facial grimacing and moaning with movement of the arm. The staff notified the resident's physician at 8:30 AM on 10/09/13, approximately 26 hours after the first observation of a change in condition on 10/08/13 at 10:00 AM. Resident #1 was transported to the local hospital on 10/09/13 at 12:45 PM, where the resident was diagnosed with a comminuted fracture (the bone had broken into several pieces) on the anterior (front) of the head and neck of the humerus (shoulder). The resident's humerus (shoulder) was also dislocated.</p>	F 000	<p><u>This plan of correction is submitted under Federal and State regulations and status applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan of correction does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this plan of correction serve as our credible allegation of compliance.</u></p> <p><u>F-157</u> <u>Corrective Action</u> The physician was notified of the change in condition for Resident # 1 on 10/09/13 at 8:30 a.m. by the Assistant Director of Nursing <u>Identify Other Residents</u> Other residents having a change in condition have the potential to be affected. A 100% skin sweep was</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Judith Branham

Executive Director

12/07/13

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 157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, hospital record review, and a review of the facility's policies, it was determined the facility</p>	F 157	<p>completed on all residents looking for a change of condition on 10/09/13 by the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the day shift Charge Nurses, with no new skin areas or changes in condition identified.</p> <p>A 30 day look-back of progress notes, physician orders and 24 hour report was conducted by DON, ADON, MDS Nurse, Unit Managers and other support RNs from corporate or other LifeCare centers to ensure there were no changes in a resident's health, mental and/or psychosocial status or any adverse effects from a current treatment that required physician or responsible party notification or further assessment, this was conducted for 11-3-13 to 12-3-13 timeframe.</p> <p>Any issues found during these reviews would have an assessment completed, physician/family notification and any new order implemented and documented in the resident's clinical record.</p> <p>A 30 day look-back of accidents/incidents was also reviewed by corporate RN to ensure</p>	

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F 157	<p>Continued From page 2</p> <p>failed to immediately consult with the resident's physician when the resident experienced a significant change in condition that required physician intervention for one of three sampled residents (Resident #1).</p> <p>Resident #1 returned from the hospital on 10/07/13 at 11:30 AM, and staff observed Resident #1 to yell out with repositioning and care; it was noted the resident had a bruise to the rib area. The nurse was notified but failed to notify the physician. On 10/08/13, at approximately 10:00 AM, and again at 3:00 PM, staff observed Resident #1 in bed with his/her right arm positioned under his/her back; the resident was not able to move his/her right arm and complained of pain when staff attempted to move his/her right arm. Staff informed Licensed Practical Nurse (LPN) #1 of the change in Resident #1's condition but the physician was not notified. On 10/09/13, at 7:15 AM staff observed bruising to Resident #1's right shoulder, scapula (shoulder blade), and the auxiliary (armpit) area, and the resident had facial grimacing and moaning with movement of the arm. The facility staff notified the physician at 8:30 AM on 10/09/13, approximately 22 hours after the first observation of a change in condition on 10/08/13 at 10:00 AM.</p> <p>Resident #1 was transported to the local hospital at 12:45 PM on 10/09/13, where the resident was diagnosed with a comminuted fracture (the bone had broken into several pieces) on the anterior (front) of the head and neck of the humerus (shoulder). The resident's humerus (shoulder) was also dislocated.</p> <p>The findings include:</p>	F 157	<p>the physician was notified and that a treatment/intervention had been implemented for 11-3-13 to 12-3-13 timeframe.</p> <p><u>Systematic Changes and Monitoring</u></p> <p>All nurses were in-serviced regarding the Change In Condition Policy and Procedure and the physician notification requirements by the DON and the ADON with in-service completed by 11-20-13, any nurse not in attendance will be in-serviced by the ADON prior to working any shift at this facility, a post test was administered to the nurses on 11-20-13 to ensure understanding of the policy. The inservice included any change in condition from the resident's baseline i.e., from accident, change in health, mental, psychosocial, adverse effects from a treatment etc. will be followed up with further assessment and immediate notification to physician for further treatment and or intervention as needed.</p> <p>Nursing staff were in-serviced between 10-9-13 to 11-21-13 that any time they reported a resident change from the resident's baseline</p>	

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F 157	<p>Continued From page 3</p> <p>Review of the facility's policy entitled "Changes in Resident's Condition or Status," not dated, revealed Nursing Services was responsible to notify the resident's physician and responsible party when there was a significant change in the resident's physical, mental, or emotional status, a need to alter the resident's treatment, or when deemed necessary in the best interest of the resident.</p> <p>Review of the facility's policy entitled "Alert Charting," not dated, revealed a nurse had the responsibility to notify the resident's physician and responsible party of significant changes, including bruising or other unusual resident events, as part of the facility's "event follow-up" (incident/accident) protocol.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 10/11/06 with diagnoses including Schizoaffective Disorder, Intracranial Injury, Seizures, and Osteoarthritis. Further review of the clinical record revealed on 07/25/13, the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was not interviewable. In addition, staff interviews also revealed the resident had moderately impaired cognitive skills. Review of nursing notes dated 10/07/13 at 5:54 AM, revealed Resident #1 had seizure-type activity at 5:30 AM. The physician was notified and the resident was transferred to the hospital.</p> <p>Interview with staff revealed Resident #1 returned from the hospital on 10/07/13 at 11:30 AM, following an evaluation of seizure-type activity. Upon the resident's return, staff observed</p>	F 157	<p>to their supervisor and there is no response in a timely manner, they should report to a nurse manager, i.e. Unit manager, DON, ADON, RN supervisor, a post test was given to validate understanding of this reporting process.</p> <p>The Interact "Stop and Watch" was in-serviced to the nursing staff between 10-9-13 to 11-21-13, which includes looking for anything different from the resident's baseline i.e., the resident communicating less, needs more help than usual, not participating in activities, eating or drinking less than usual, change in weight, more agitated or nervous than usual, more confused, weak, tired or drowsy, or needs more assistance with ADLs. The certified nursing assistant fills out the "Stop and Watch" form for any of these changes and the completed form is turned into the charge nurse who then must assess, evaluate and respond to this change of condition. A post test was given to validate understanding of the use of the "Stop and Watch" form.</p>		

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F 157	<p>Continued From page 4</p> <p>Resident #1 to yell out when he/she was repositioned and care was provided. Staff observed the resident had a bruise to the rib area. Further interview revealed staff notified a nurse of the resident's condition; however, the nurse failed to document an assessment of the resident and failed to inform the resident's physician of the change in the resident's condition.</p> <p>Observations on 10/22/13 at 12:30 PM, 3:30 PM, 5:30 PM, and 7:00 PM, revealed Resident #1 lying in the bed with a sling and swath (used to prevent movement of an upper extremity) on his/her right arm. An attempt to interview Resident #1 was unsuccessful due to the resident's limited cognition.</p> <p>Interview on 10/22/13 at 4:50 PM with State Registered Nursing Assistant (SRNA) #2 revealed on 10/07/13 after Resident #1 returned from the hospital, she reported to Registered Nurse (RN) #1 that Resident #1 yelled out every time the SRNAs moved the resident; and the resident had a bruise to the rib area. According to SRNA #2, RN #1 assessed Resident #1; however, the SRNA was unaware of the actions of the RN after the assessment.</p> <p>Continued review of nursing notes dated 10/08/13 at 3:30 AM, revealed a new physician's order for staff to utilize a mechanical lift "as needed" when staff transferred Resident #1; however, there was no documented evidence the resident's physician had been informed of the resident's inability to move his/her right arm, or of the resident's facial expression of pain upon movement.</p> <p>Interview on 10/22/13 at 5:00 PM with SRNA #3</p>	F 157	<p>The nurse management to include, unit managers, MDS nurse, medical records nurse, admissions nurse and other support RN nurses from corporate or other Life Care Centers will perform audits of physician orders, 24 hour report, "Stop and Watch" and progress notes Monday through Friday utilizing the Change in Condition Log to validate Change of Condition Policy was followed, i.e., assessment completed and physician/family notification and any new orders implemented and documented in the resident's clinical record. These Change of Condition logs will be turned into the DON and or ADON Monday through Friday.</p> <p>The DON and or ADON validation audits will be completed Monday through Friday and consist of weekly checking 10 random residents listed on Change of Condition log for 30 days and then 5 random residents listed on Change of Condition log for next 30 days and then 3 random residents listed on Change of Condition Log for next 30 days. They will be validating Change of Condition Policy was</p>	

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F 157	<p>Continued From page 5</p> <p>revealed after breakfast on 10/08/13, Resident #1 would "yell out" and resist when she tried to reposition him/her. SRNA #3 stated at approximately 10:00 AM on 10/08/13 she noticed Resident #1 lying on his/her right arm, the resident was unable to remove the arm from underneath him/her, and the resident's arm was "lifeless." The interview revealed at that time the SRNA reported the change in Resident #1's condition to Licensed Practical Nurse (LPN) #1. According to SRNA #3, Resident #1 also had a dark bruise to the collarbone. Interview with SRNA #3 revealed she informed LPN #1 again of the resident's condition on 10/08/13 at approximately 3:00 PM. However, the SRNA was not aware if LPN assessed the resident at that time.</p> <p>Interview on 10/22/13 at 5:45 PM, with SRNA #4 revealed on 10/08/13, during the 10:00 AM rounds, she observed Resident #1 lying with his/her right arm behind his/her back. SRNA #4 stated the resident grimaced every time his/her right arm was moved. The interview revealed the SRNA reported the change in the resident's condition to LPN #1 at that time. SRNA #4 stated she again reported the change in condition to LPN #1 at approximately 3:00 PM on 10/08/13. SRNA #4 stated she did not witness the LPN enter Resident #1's room to assess the resident's condition. SRNA #4 stated Resident #1 also had a black bruise to the right shoulder area, but she had not reported the bruise to the LPN.</p> <p>Interview on 10/23/13 at 10:05 AM with SRNA #6 revealed at the beginning of her shift on 10/08/13, at approximately 7:00 PM, SRNA #4 reported to her that Resident #1's right arm was "messed up" and that even though the SRNAs had reported</p>	F 157	<p>followed, i.e., assessment completed and physician/family notification and any new orders implemented and documented in the clinical record.</p> <p>A 100% skin sweep was performed on all residents for 2 weeks starting 11/19/13 and week of 11/26/13 by the DON, ADON, Unit Managers, Medical records nurse, Admission Nurse, MDS nurse and other support RNs from corporate or other Life Care centers, this is in addition to the required skin assessments completed weekly by the charge nurses. Random skin checks will be completed by same nurses mentioned above on 10 residents a week for 4 weeks, 5 residents a week for next 4 weeks and 2 residents a week for next 4 weeks. These additional skin assessments are compared to the charge nurse weekly skin assessments for validation that any change of conditions were noted and for physician/family notification and any new orders implemented and documented in the clinical record.</p>		

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F 157	<p>Continued From page 6</p> <p>the change in the resident's condition to LPN #1, nothing had been done for the resident. SRNA #6 stated Resident #1 had "screamed" when staff touched the resident's right arm while she had provided care that night. However, SRNA #6 did not report the resident's response to care to the evening shift nurse. According to SRNA #6, she had been told the day shift nurse was aware of the change in the resident's condition and assumed the nurse would have passed the information on to the evening nurse during shift report.</p> <p>Interview on 10/22/13 at 4:10 PM with LPN #1 revealed on 10/08/13, SRNAs #3 and #4 reported a change in Resident #1's condition to her. According to LPN #1, the SRNAs reported the resident would roll onto his/her right arm and was unable to move his/her arm. LPN #1 acknowledged she observed a dark purple bruise on Resident #1's clavicle on 10/08/13; however, the resident was able to move the right arm when she had asked him/her. The LPN stated she was unaware of any injuries sustained by Resident #1 that could have resulted in the bruise. Further interview revealed LPN #1 did not notify the resident's physician of the dark purple bruise, or of the information reported by the SRNAs related to a change in the resident's condition. LPN #1 acknowledged that according to the facility's policy it was the nurses' responsibility to contact the resident's physician with any change in the resident's condition and to document any changes or assessments in the nursing notes in the medical record.</p> <p>Review of the nursing note dated 10/09/13 at 2:08 AM, revealed the resident required the total assistance of two to four staff members for care</p>	F 157	<p>Any resident that leaves the center for a medical appointment will have a skin assessment completed upon return to the center looking for a change from the resident's baseline. This assessment will be audited by the Unit Managers, Weekend Supervisor, or Manager on Duty for completion and physician/family notification and any new orders implemented and documented in the clinical record.</p> <p>Any nurses found to not be following the change of condition policy will be re-in-serviced and or receive disciplinary action.</p> <p>The results of the audits will be reviewed and summarized weekly for first 4 weeks, and then twice a month next 8 weeks by DON and Administrator to evaluate compliance with Change of Condition policy, i.e. nurse assessment of any possible change of resident, physician and family notification and any new orders received were implemented and documented in the clinical record.</p> <p><u>Performance Improvement</u></p> <p>The PI committee (Administrator, DON, ADON, MDS nurse, Social</p>		

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F 157	<p>Continued From page 7</p> <p>because of the resident's resistant behaviors.</p> <p>Review of a late entry nursing note dated 10/09/13 at 3:14 PM, revealed at approximately 7:15 AM on 10/09/13, staff observed "dark bluish/purple/black" bruising to Resident #1's right shoulder, scapula (shoulder blade), and the auxiliary (armpit) area. The nursing note revealed Resident #1 had facial grimacing and moaning with movement of his/her right arm, and was "grabbing" with his/her left hand at his/her shoulder area. Further review of the nursing note revealed facility staff notified Resident #1's physician of the change in the resident's condition on 10/09/13 at 8:30 AM, and the resident was transported to the hospital on 10/09/13 at 12:45 PM for evaluation and treatment.</p> <p>Review of the hospital medical record revealed a Computed Tomography (CT) scan obtained of Resident #1's right shoulder on 10/09/13 revealed a "Comminuted fracture from the humeral head and neck with multiple fragments seen in the shoulder joint," and "Anterior cephalad dislocation of the humeral head."</p> <p>Interview on 10/23/13 at 11:00 AM with SRNA #5 revealed on the morning of 10/09/13 the SRNA noted something was wrong with Resident #1's arm; the SRNA stated the resident's arm was like a "dead arm." SRNA #5 stated he reported the resident's condition to LPN #2 and the LPN stated that nothing had been reported to her in shift report or throughout the night. The interview revealed LPN #2 assessed the resident, notified the resident's physician, and obtained physician's orders to transfer the resident to the hospital. SRNA #5 stated Resident #1 had a T-shirt on and there was a visible dark bruise located on the</p>	F 157	<p>Services, Unit Managers, Activities Director, Dietary Manager, Medical Records, Admission Nurse, Therapy Director, Business Office Manager and Medical Director) will meet 12-5-13 to review this Plan of Correction for understanding of the required monitoring.</p> <p>The PI committee will meet weekly for 30 days to review results of all audits for compliance with this Plan of Correction. The QAPI committee will make recommendations based on outcomes of the audits.</p> <p>The PI committee will meet monthly ongoing per policy and review all audit results associated with this Plan of Correction for compliance with this plan.</p> <p>Date of compliance: 12/7/13</p>		

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F 157	<p>Continued From page 8 right side of the resident's shirt collar.</p> <p>Review of LPN #2's written statement, obtained by the facility on 10/10/13, revealed on 10/09/13 at approximately 7:05 AM SRNA #5 asked the LPN about Resident #1's right arm. According to LPN #2's written statement, she assessed Resident #1, attempted to perform range of motion to the resident's arm, and the resident appeared to be in visible pain when moving his/her arm. The statement also revealed the resident had "deep purple bruising" to his/her armpit and shoulder.</p> <p>Attempts to interview LPN #2 on 10/22/13 at 6:15 PM, and on 10/23/13 at 8:00 AM, by telephone were unsuccessful; there was no answer and no voice mail to leave a message. Review of LPN #2's written statement confirmed that she had been informed of Resident #1's condition by SRNA #5, had contacted the resident's physician, and had transferred the resident to the hospital.</p> <p>Interview on 10/22/13 at 6:00 PM with RN #1 revealed Resident #1 had experienced a seizure on 10/07/13 at approximately 5:30 AM, and had been transported to the local hospital for evaluation and treatment prior to her scheduled shift on 10/07/13 that began at 7:00 AM. RN #1 stated she did not conduct a skin assessment upon Resident #1's return to the facility on 10/07/13 at approximately 11:30 AM and stated staff had not reported a change in Resident #1's condition at the time of his/her return to the facility or during the remainder of her shift on 10/07/13.</p> <p>Interview on 10/22/13 at 7:15 PM with the Assistant Director of Nursing (ADON) revealed on 10/09/13, at approximately 8:00 AM, SRNA #5</p>	F 157		

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F 157	<p>Continued From page 9</p> <p>reported to her something was wrong with Resident #1's right arm and the ADON went to Resident #1's room. The ADON stated, "I could tell from the door" that the resident's right shoulder was higher than the left shoulder. The ADON stated the resident's right shoulder was swollen to the point that the resident's T-shirt sleeve was tight on the resident's arm. The interview revealed Resident #1 would not allow the staff to remove the shirt; however, there was visible edema and bruising noted. The ADON stated that when she attempted to move Resident #1's right arm the resident "yelled out in pain." The ADON confirmed the resident's physician was immediately notified of the change in the resident's condition and the resident was transported to the hospital for further evaluation and treatment.</p> <p>Interview on 10/22/13 at 7:15 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed nurses were responsible to notify the resident's physician and responsible party if a resident experienced a change in condition. The interview confirmed LPN #1 had not conducted a thorough assessment of Resident #1 and had not notified Resident #1's physician of the change in the resident's condition on 10/08/13 at approximately 10:00 AM, or at 3:00 PM after staff reported the resident's change to the nurse. The DON stated LPN #1 was suspended during the investigation, received a written reprimand, and was allowed to return to work after she had been re-educated on the facility's policies.</p> <p>Interview with the Administrator on 10/22/13 at 8:20 PM revealed she had the responsibility to ensure Administrative staff implemented the</p>	F 157		

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F 157	Continued From page 10 facility's policies. In addition, the Administrator stated staff discussed areas of concern in the QA meetings, and she had been made aware of the incident and Resident #1's medical condition by the DON on 10/09/13. The Administrator stated the DON had conducted an investigation of Resident #1's injuries and had kept the Administrator updated on the progress of the investigation of how the injuries occurred.	F 157			
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, hospital record review, facility policy review, and review of Nursing Practice Standards, it was determined the facility failed to ensure services provided met professional standards for one of three sampled residents (Resident #1). Interview with staff revealed Resident #1 returned from the hospital on 10/07/13 at 11:30 AM following an evaluation of seizure-type activity and upon the resident's return, staff observed Resident #1 to yell out with repositioning and care and noted the resident had a bruise to the rib area. Interview revealed staff notified a nurse of the resident's condition; however, the nurse failed to document an assessment of the resident and failed to inform the resident's physician of the change In addition, interview revealed on 10/08/2013, at approximately 10:00 AM and 3:00 PM staff	F 281	<u>F-281</u> <u>Corrective Action</u> On 10/09/13 at 7:15 a.m. Resident # 1 was assessed for a Change in Condition. Assessment was documented on 10/09/13 at 3:14 p.m. by the Assistant Director of Nursing. <u>Identify Other Residents</u> Other residents having a change in condition have the potential to be affected. A 100% skin sweep was completed on all residents looking for a change of condition on 10/09/13 by the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the day shift Charge Nurses, with no new skin areas or changes in condition identified. A 30 day look-back of progress notes, physician orders and 24 hour report was conducted by DON, ADON, MDS Nurse, Unit Managers and other support RNs from corporate or other LifeCare centers		

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F 281	<p>Continued From page 11</p> <p>informed LPN #1 that Resident #1 was lying on his/her right arm, was unable to move his/her right arm, and grimaced and yelled when staff attempted to move his/her arm or reposition the resident. However, LPN #1 failed to document an assessment of Resident #1's condition and failed to inform the physician of the resident's condition/complaints of pain. On 10/09/13 at 7:15 AM, the resident was noted to have "dark bluish/purple/black" bruising to the right shoulder, scapula (shoulder blade), and the auxiliary (armpit) area, and facial grimacing and moaning with movement of his/her right arm.</p> <p>On 10/09/13 at 8:30 AM facility staff notified Resident #1's physician of the change in the resident's condition and the resident was transported to the hospital on 10/09/13 at 12:45 PM for evaluation and treatment. Resident #1 was diagnosed with a comminuted fracture (the bone had broken into several pieces) on the anterior (front) of the head and neck of the humerus (shoulder). The resident's humerus (shoulder) was also dislocated.</p> <p>The findings include:</p> <p>Review of the National Federation of Licensed Practical Nurses publication dated October 2003, entitled "Nursing Practice Standards for the Licensed Practical/Vocational Nurse," section "Practice," revealed "The Licensed Practical/Vocational Nurse ...4. Shall know and utilize the nursing process in planning, implementing and evaluating health services and nursing care for the individual patient or group," and "Planning: The planning of nursing includes: 1) assessment/data collection of health status of the individual patient, the family and community</p>	F 281	<p>to ensure there were no changes in a resident's health, mental and/or psychosocial status or any adverse effects from a current treatment that required physician or responsible party notification or further assessment, this was conducted for 11-3-13 to 12-3-13 timeframe.</p> <p>Any issues found during these reviews would have an assessment completed, physician/family notification and any new order implemented and documented in the resident's clinical record.</p> <p>A 30 day look-back of accidents/incidents was also reviewed by corporate RN to ensure the physician was notified and that a treatment/intervention had been implemented for 11-3-13 to 12-3-13 timeframe.</p> <p><u>Systematic Changes and Monitoring</u> All nurses were in-serviced regarding the Change In Condition Policy and Procedure and the physician notification requirements by the DON and the ADON with in-service completed by 11-20-13, any nurse not in attendance will be in-serviced by the ADON prior to</p>		

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F 281	<p>Continued From page 12 groups. 2) reporting information gained from assessment/data collection."</p> <p>Review of the facility's policy entitled "Changes in Resident's Condition or Status," undated, revealed "All changes in the resident's medical condition must be properly recorded in the resident's medical record in accordance with the documentation policies and procedures."</p> <p>Review of the facility's policy entitled "Alert Charting," undated, revealed changes in physical, mental, behavioral, medical, and functional status "must be documented and monitored." The policy further stated an event follow-up which included bruises or other unusual resident event must be documented in the resident's medical record.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 10/11/06 with diagnoses including Seizures and Osteoarthritis. On 07/25/13, the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident had limited cognition and was not interviewable.</p> <p>Review of nursing notes dated 10/07/13 at 5:54 AM, revealed Resident #1 had seizure-type activity at 5:30 AM, the resident was rigid for 10 minutes with no pupil reaction for 20 minutes, and staff administered oxygen to the resident. Facility staff contacted the resident's physician and transferred the resident to the hospital for further evaluation and treatment.</p> <p>Interview on 10/22/13 at 4:50 PM, with State Registered Nursing Assistant (SRNA) #2 revealed on 10/07/13, after the resident returned to the</p>	F 281	<p>working any shift at this facility, a post test was administered to the nurses on 11-20-13 to ensure understanding of the policy. The in-service included any change in condition from the resident's baseline i.e., from accident, change in health, mental, psychosocial, adverse effects from a treatment etc. will be followed up with further assessment and immediate notification to physician for further treatment and or intervention as needed.</p> <p>Nursing staff were in-serviced between 10-9-13 to 11-21-13 that any time they reported a resident change from the resident's baseline to their supervisor and there is no response in a timely manner, they should report to a nurse manager, i.e. Unit manager, DON, ADON, RN supervisor, a post test was given to validate understanding of this reporting process.</p> <p>The Interact "Stop and Watch" was in-serviced to the nursing staff between 10-9-13 to 11-21-13, which includes looking for anything different from the resident's baseline i.e., the resident</p>		

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F 281	<p>Continued From page 13</p> <p>facility from the hospital on the day shift, she reported to Registered Nurse (RN) #1 that Resident #1 yelled out every time the SRNAs moved the resident and that the resident had a bruise to the rib area. According to SRNA #2, RN #1 assessed Resident #1; however, the SRNA was unaware of the actions of the RN after the assessment.</p> <p>RN #1 stated in interview conducted on 10/22/13 at 6:00 PM that she worked the day shift on 10/07/13 and provided care to Resident #1. RN #1 stated she worked the 7:00 AM to 7:00 PM shift, and prior to the start of her shift Resident #1 experienced a seizure and was transported to the local hospital. According to RN #1, she did not conduct a skin assessment of Resident #1 when he/she returned to the facility from the hospital at approximately 11:30 AM on 10/07/13. RN #1 stated no one had reported a change in Resident #1's condition during the remainder of her shift.</p> <p>Continued review of nursing notes dated 10/08/13 at 3:30 AM, revealed a physician's order for staff to utilize a mechanical lift "as needed" when they transferred Resident #1.</p> <p>Interview on 10/22/13 at 5:00 PM with SRNA #3 revealed she worked the day shift on 10/08/13 and following breakfast, Resident #1 resisted care and yelled out when she attempted to reposition him/her, which was not reported. SRNA #3 stated at approximately 10:00 AM she noticed Resident #1 lying on his/her right arm. According to SRNA #3, Resident #1 was unable to move his/her right arm, the resident's right arm was "lifeless," and the resident had a dark bruise to the side of the neck. SRNA #3 stated she informed LPN #1 of the resident's condition;</p>	F 281	<p>communicating less, needs more help than usual, not participating in activities, eating or drinking less than usual, change in weight, more agitated or nervous than usual, more confused, weak, tired or drowsy, or needs more assistance with ADLs. The certified nursing assistant fills out the "Stop and Watch" form for any of these changes and the completed form is turned into the charge nurse who then must assess, evaluate and respond to this change of condition. A posttest was given to validate understanding of the use of the "Stop and Watch" form.</p> <p>The nurse management to include, unit managers, MDS nurse, medical records nurse, admissions nurse and other support RN nurses from corporate or other Life Care Centers will perform audits of physician orders, 24 hour report, "Stop and Watch" and progress notes Monday through Friday utilizing the Change in Condition Log to validate Change of Condition Policy was followed, i.e., assessment completed and physician/family notification and any new orders</p>		

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F 281	<p>Continued From page 14</p> <p>however, she did not see the LPN check the resident's status. In addition, SRNA #3 stated the resident's condition remained the same throughout her shift and at 3:00 PM she again informed LPN #1 of the resident's condition. The interview revealed nothing had been done for Resident #1 when the SRNA left work at 7:00 PM that evening.</p> <p>Interview on 10/22/13 at 5:45 PM with SRNA #4 revealed she had also worked the day shift on 10/08/13 and observed Resident #1 lying with his/her right arm behind the resident's back and stated the resident would grimace any time he/she, or staff, attempted to move the resident's right arm. The interview revealed the SRNA reported Resident #1's change in condition to LPN #1 twice during that shift. SRNA #4 stated Resident #1 also had a black bruise to the right shoulder area.</p> <p>Interview on 10/22/13 at 4:10 PM with LPN #1 revealed the LPN worked the day shift on 10/08/13 and had provided care to Resident #1. The LPN stated SRNAs #3 and #4 reported Resident #1 had rolled onto his/her right arm and was unable to move the arm. The interview revealed LPN #1 assessed Resident #1 and observed a dark purple bruise on the resident's clavicle; however, the LPN stated the resident was able to move his/her right arm. LPN #1 stated she was unaware of any injuries Resident #1 had sustained during her shift and had not documented the SRNAs' report that Resident #1 was unable to move his/her right arm and yelled when facility staff attempted to reposition him/her. In addition, LPN #1 stated she did not notify the resident's physician of the dark purple bruise or of the information reported by the SRNAs. LPN #1</p>	F 281	<p>implemented and documented in the resident's clinical record. These Change of Condition logs will be turned into the DON and or ADON Monday through Friday. The DON and or ADON validation audits will be completed Monday through Friday and consist of weekly checking 10 random residents listed on Change of Condition log for 30 days and then 5 random residents listed on Change of Condition log for next 30 days and then 3 random residents listed on Change of Condition Log for next 30 days. They will be validating Change of Condition Policy was followed, i.e., assessment completed and physician/family notification and any new orders implemented and documented in the clinical record.</p> <p>A 100% skin sweep was performed on all residents for 2 weeks starting 11/19/13 and week of 11/26/13 by the DON, ADON, Unit Managers, Medical records nurse, Admission Nurse, MDS nurse and other support RNs from corporate or other Life Care centers, this is in addition to the required skin</p>	

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F 281	<p>Continued From page 15</p> <p>acknowledged that in accordance with the facility's "Change in Condition" policy nurses were to notify the resident's physician and document any changes in a resident's condition.</p> <p>Interview on 10/23/13 at 10:05 AM with SRNA #6 revealed she worked the evening shift (7:00 PM to 7:00 AM) on 10/08/13 and provided care to Resident #1. SRNA #6 stated during shift report SRNA #4 reported Resident #1's right arm was "messed up" and that the day shift SRNAs had already reported the change in condition to LPN #1. However, SRNA #6 stated that according to SRNA 4, the LPN did not assess the resident. SRNA #6 stated Resident #1 "screamed" in pain anytime the staff touched the resident's right arm. According to SRNA #6, she did not report the resident's condition to the nurse on the second shift (LPN #2) because the SRNAs on the day shift had already informed the day shift nurse of the change in the resident's condition.</p> <p>Review of a nursing note dated 10/09/13 at 2:08 AM, revealed the resident required the total assistance of two to four staff members for care because of the resident's resistant behaviors.</p> <p>Interview on 10/23/13 at 11:00 AM with SRNA #5 revealed on the morning shift on 10/09/13, the SRNA noted something was wrong with Resident #1's arm; it was like a "dead arm." SRNA #5 stated he asked the night shift nurse (LPN #2) about the resident's condition. SRNA #5 stated LPN #2 informed him no one had reported any issues related to Resident #1's condition to her in the report she had received from the previous shift and no one had reported any concerns related to Resident #1 to her throughout the night. According to SRNA #5, Resident #1 had a T-shirt</p>	F 281	<p>assessments completed weekly by the charge nurses. Random skin checks will be completed by same nurses mentioned above on 10 residents a week for 4 weeks, 5 residents a week for next 4 weeks and 2 residents a week for next 4 weeks. These additional skin assessments are compared to the charge nurse weekly skin assessments for validation that any change of conditions were noted and for physician/family notification and any new orders implemented and documented in the clinical record.</p> <p>Any resident that leaves the center for a medical appointment will have a skin assessment completed upon return to the center looking for a change from the resident's baseline. This assessment will be audited by the Unit Managers, Weekend Supervisor, or Manager on Duty for completion and physician/family notification and any new orders implemented and documented in the clinical record. Any nurses found to not be following the change of condition</p>	

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F 281	<p>Continued From page 16</p> <p>on and there was a visible dark bruise located on the right side of the resident's shirt collar.</p> <p>Review of documentation revealed the facility had obtained a written statement from LPN #2 on 10/10/13 related to an incident that involved Resident #1. Review of the statement revealed on 10/09/13 at approximately 7:05 AM, SRNA #5 asked LPN #2 about Resident #1's right arm. According to LPN #2's written statement, the LPN assessed Resident #1, attempted to perform range of motion on the resident's right arm, and the resident was in visible pain with movement of the arm. LPN #2 documented she immediately notified Resident #1's physician of the change in the resident's condition and received physician's orders, and then the resident was transported to the hospital for further treatment.</p> <p>Review of a late entry in the nursing notes by LPN #2, dated 10/09/13 at 3:14 PM, revealed at approximately 7:15 AM on 10/09/13 staff observed "dark bluish/purple/black" bruising to Resident #1's right shoulder, scapula (shoulder blade), and the auxiliary (armpit) area. The nursing note revealed Resident #1 had facial grimacing and moaning with movement of his/her right arm and was "grabbing with (his/her) left hand at (his/her) shoulder area." Further review of the nursing note revealed facility staff notified Resident #1's physician of the change in the resident's condition on 10/09/13 at 8:30 AM. The resident was transported to the hospital on 10/09/13 at 12:45 PM for evaluation and treatment.</p> <p>Review of a radiology report, dated 10/09/13, revealed Resident #1 sustained a "comminuted fracture from the humeral head and neck with</p>	F 281	<p>policy will be re-in-serviced and or receive disciplinary action.</p> <p>The results of the audits will be reviewed and summarized weekly for first 4 weeks, and then twice a month next 8 weeks by DON and Administrator to evaluate compliance with Change of Condition policy, i.e. nurse assessment of any possible change of resident, physician and family notification and any new orders received were implemented and documented in the clinical record.</p> <p><u>Performance Improvement</u></p> <p>The PI committee (Administrator, DON, ADON, MDS nurse, Social Services, Unit Managers, Activities Director, Dietary Manager, Medical Records, Admission Nurse, Therapy Director, Business Office Manager and Medical Director) will meet 12-5-13 to review this Plan of Correction for understanding of the required monitoring.</p> <p>The PI committee will meet weekly for 30 days to review results of all audits for compliance with this Plan of Correction. The QAPI committee will make recommendations based on outcomes of the audits.</p>		

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F 281	<p>Continued From page 17</p> <p>multiple fragments seen in the shoulder joint. Anterior cephalad dislocation of the humeral head" (the long bone of the right arm and shoulder joint was splintered/fragmented and the shoulder was displaced from the normal position).</p> <p>Observations on 10/22/13 at 12:30 PM, 3:30 PM, 5:30 PM, and 7:00 PM revealed Resident #1 was in the bed, and a sling and swath was observed on the right arm. Attempts to interview Resident #1 were unsuccessful due to the resident's limited cognition.</p> <p>Interview on 10/22/13 at 7:15 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed nurses were responsible to conduct an assessment of the resident and notify the resident's physician and responsible party if the resident experienced a change in condition. The DON and ADON confirmed LPN #1 did not document an assessment of Resident #1 or notify the resident's physician of a change in the resident's condition. According to the ADON, on 10/09/13 at approximately 8:00 AM SRNA #5 reported something was wrong with Resident #1's right arm and the ADON went to Resident #1's room to assess the resident. The ADON stated, "I could tell from the door" that the resident's right shoulder was higher than the left shoulder. The ADON stated the resident's right shoulder was swollen to the point that the resident's T-shirt sleeve was tight on the resident's arm. The interview revealed Resident #1 would not allow the staff to remove the shirt; however, there was visible edema and bruising noted. The ADON stated she attempted to move Resident #1's right arm, the resident "yelled out in pain," and the resident's physician was immediately notified of</p>	F 281	<p>The PI committee will meet monthly ongoing per policy and review all audit results associated with this Plan of Correction for compliance with this plan.</p> <p>Date of compliance: 12/7/13</p>		

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

PRINTED: 11/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/2013
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F 281	<p>Continued From page 18</p> <p>the resident's change in condition. Interview revealed Resident #1 was transported to the hospital for further evaluation and treatment.</p> <p>Interview with the Administrator on 10/22/13 at 8:20 PM revealed she attended Quality Assurance (QA) meetings at the facility and staff concerns were discussed. According to the Administrator, the DON conducted the investigation of Resident #1's injury and updated the Administrator as the investigation progressed. The Administrator stated she was responsible to ensure the other Administrative staff implemented the facility's policies, and acknowledged the staff had failed to assess and notify Resident #1's physician of a change in the resident's condition in a timely manner.</p>	F 281		