

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

PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/18/2012
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
(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	
F 222	<p>Continued From page 1</p> <p>"Documentation Guidelines," revised 01/08, revealed the reason for giving PRN medication and it's effect must be recorded each time the PRN medication is given. Notes were to be recorded on the PRN record or in the nursing notes.</p> <p>A closed record review revealed Resident #1 was admitted to the facility on 12/09/11 with diagnoses to include Dementia with Behavioral Disturbance, Chronic Airway Obstruction, Cerebral Artery Occlusion and History of Malignant Neoplasm. Further review revealed the resident had a history of behaviors, with a recent admission to a behavioral facility due to behaviors of throwing food at caregivers, aggressive tendencies, wandering in others' rooms, disrobing, resisting care, defecating and urinating in inappropriate places.</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 12/16/11, revealed the facility assessed the resident to be severely cognitively impaired. He/she required extensive assistance with all activities of daily living (ADLs) and had care plan interventions for staff to anticipate and assist with all his/her needs.</p> <p>Further review of a physician's telephone order, dated 12/16/11 at 2:40 PM, revealed "Ativan 0.50 mg IM every two hours PRN for agitation/restlessness, may increase the dose to Ativan one (1) mg IM PRN if agitation worsens." Further review revealed the Ativan IM PRN was ordered due to the resident being redirected several times and the resident's attempts to block another resident's room, insisting it was his/her home. Ativan 0.50 mg IM PRN was administered</p>	F 222	<p>F 222 cont'd</p> <p>indications for use and effectiveness charting. This will be the responsibility of the Director of Nursing and the nursing management team. This will be accomplished by regular review of physician orders, nursing notes, and documentation of anti-anxiety medications located on the MAR's that identify psychoactive medications requiring monitoring.</p> <p>The Director of Nursing will monitor compliance of indications, effectiveness for use, and orders for one time administration of IM anti-anxiety medications through the Quality Assurance Process. The DON will review indications and effectiveness for use, and orders for one time administration of IM psychoactive medications monthly x 3 beginning in February 2012 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.</p>	1/25/12	

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F 222	<p>Continued From page 2</p> <p>at that time. There was no documentation of the effect of the Ativan IM PRN.</p> <p>A review of a nurses' note, dated 12/17/11 at 8:00 PM, revealed the resident was found on the floor, assisted back to bed with no indications of pain; however, he/she was unable to respond to questions appropriately. A review of the Medication Administration Record (MAR), dated 12/17/11 at 8:30 PM, revealed the resident received Ativan 0.50 mg IM PRN, and at 8:45 PM, he/she was sent to the emergency room for an evaluation of pain.</p> <p>A review of a nurses' note, dated 12/18/11 at 3:30 AM, revealed the resident returned to the facility from the emergency room. He/she was alert and verbal. There was no documented evidence in the nurses' notes related to the administration of the Ativan IM PRN; however, a review of the MAR revealed Ativan 0.50 mg IM PRN was administered on 12/18/11 at 3:30 AM. There was no reason nor any result documented for the Ativan IM PRN.</p> <p>Further review of the MAR revealed Ativan 0.50 mg IM PRN was administered on 12/18/11 at 7:50 AM. There was no documented evidence on the MAR to indicate the reason for the Ativan IM PRN or the result.</p> <p>An interview with Registered Nurse (RN) #1, on 01/18/11 at 12:45 PM, revealed Resident #1 was very restless most of the time, urinating in inappropriate places, but he/she never hit or hurt anyone. She stated the MDS Coordinator made a request for her "to call and get something" when Resident #1 attempted to block another</p>	F 222			

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F 222	<p>Continued From page 3</p> <p>resident's room, and that the resident's behavior was not unusual. RN #1 revealed she notified the physician for the Ativan IM PRN order because she was instructed to do so.</p> <p>An interview with RN #2, on 01/18/12 at 1:00 PM, revealed she administered Ativan IM PRN to Resident #1 and documented on the back of the MAR. She revealed she did not document the reason for the administration of the PRN medications or the results of the PRN medications. RN #2 stated "I don't have any memory of the incident."</p> <p>An interview with RN #3, on 01/18/12 at 1:10 PM, revealed he administered Ativan IM PRN to Resident #1, on 12/16/11, due to wandering and resisting redirection. RN #3 revealed Resident #1 yelled at times, but did not recall any acts of self-harm or harm to others. He further revealed that he administered Ativan IM PRN, on 12/17/11 at 8:30 PM, to Resident #1 after a fall. He stated after the fall, the staff were having difficulty keeping the resident in the bed and getting him/her to be more cooperative with care, because the resident appeared to be confused. RN #3 stated he "didn't have anything else to help control the behavior of crawling out of the bed" and there was a potential increased risk for falling.</p> <p>An interview with the MDS Coordinator, on 01/18/12 at 3:20 PM, revealed she attempted to do Resident #1's assessment, on 12/16/11, and the resident told her "to get out." The MDS Coordinator stated the resident was not a danger to anyone, but could be a danger to himself/herself due to confusion and an unsteady</p>	F 222		

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F 222	Continued From page 4 gait. She told the unit nurse the resident needed something to calm him/her down, but did not recall what medication was obtained. An interview with the Director of Nursing (DON), on 01/18/12 at 12:30 PM and at 4:30 PM, revealed she was away from the facility during the times Resident #1 received the Ativan IM PRN injections. The DON revealed a new RN obtained and wrote the order, but she did not agree with the way the order was written. If the resident required an IM injection it should be a one time order and not a PRN. Additionally, the DON revealed she expected the reason for administering a PRN medication and the results of the PRN medication to be documented.	F 222			