

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

PRINTED: 05/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2010
NAME OF PROVIDER OR SUPPLIER ST LUKE HOSPITAL EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 85 NORTH GRAND AVENUE FORT THOMAS, KY 41075	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Recertification Survey was initiated on 04/20/10 and concluded on 04/22/10, and a Life Safety Code Survey was conducted on 04/20/10. Deficiencies were cited with the highest scope and severity of an "F".	F 000		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272	Please accept this Plan of Correction as the St. Luke Hospital East Skilled Nursing Facility's credible allegation of substantial compliance effective <u>June 6, 2010</u> for the deficiencies noted from the survey completed April 22, 2010. It is our intent that we have substantially corrected our deficiencies per requirements in 42 CFR Part 483 subpart B. F272 MDS Nurse RN and MDS Nurse LPN reviewed the 4 criteria for the development of the RAPs on April 22 with the Administrator and then integrated criteria into developing new RAPs. For resident #2 and #7 the period for revision had ended so no changes to their RAPs could be made. See Attachment A. These criteria will be used in developing all new RAPs. The Administrator will monitor RAPs on all new admissions x 1 month; then randomly to ensure compliance with criteria. See Attachment B. RECEIVED MAY 17 2010	6/6/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Wendy Bauer, NHA* TITLE: *Administrative* (X6) DATE: *5/14/10*

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 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure comprehensive assessments were completed in accordance with Utilization Guidelines specified as part of the Resident Assessment Instrument (RAI) for two (2) of ten (10) sampled residents (Residents #2 and #7). Areas that triggered for further assessment and individualized care plans were not thoroughly reviewed so that an individualized care plan could be developed for Residents #2, and #7.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Record review revealed Resident #7's Admission assessment, completed 04/20/10, triggered "Dehydration/Fluid Maintenance. However, the facility failed to use the Resident Assessment Protocol Summary (RAPS) guidelines to identify and document relevant assessment information. <p>Review of the RAP Summary related to Dehydration/Fluid Maintenance revealed that three (3) of four (4) components required in the RAP Summary had not been addressed. Complications and risk factors that would affect the decision to proceed to care planning were not fully addressed. Resident #7 had Congestive Heart Failure (CHF) and received Lasix (diuretic) daily. However, the potential for risk of dehydration was not addressed. Factors to be considered in developing individualized care plan interventions such as; monitor intake and output, vital signs, and edema was not addressed. The need for referrals for further evaluation by</p>	F 272			

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F 272	Continued From page 2 appropriate Health Professionals were also not addressed. 2. Review of the medical record revealed Resident #2 had diagnoses which included Dysphagia, Chronic Obstructive Pulmonary Disease Exacerbation, Hypothyroidism, and Hypertension. Review of the Admission Minimum Data Set (MDS) dated 04/21/10 revealed the facility had identified eight (8) Resident Assessment Protocol problem areas for Resident #2. Review of the RAP Summary revealed Nutritional Status triggered for Resident #2 due to a gastrostomy tube. Review of the RAP Summary revealed risk factors associated with gastrostomy tubes were not addressed. Documentation related to the RAP assessment, Dietary and Speech Therapy Notes, did not include this information. Further review revealed the possible need for referrals, was not addressed. Interview with the MDS Coordinator, RN #3 on 04/22/10 at 11:22 AM, revealed she was unaware of the guidelines for completing the RAP Summaries from the RAP trigger sheet in the MDS. Interview with LPN #1, who assists the MDS Coordinator with completing MDS forms, on 04/22/10 at 10:40 AM revealed she was unaware of the written guidelines on the RAP trigger sheet.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		

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F 278	<p>Continued From page 3</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure Minimum Data Sets (MDS) assessments were signed and dated by a Registered Nurse (RN) certifying completion of the assessment for one (1) of ten (10) sampled residents (Resident #7).</p> <p>The findings include:</p> <p>Review of the clinical record revealed that Resident #7 was admitted to the facility on</p>	F 278		

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F 278	Continued From page 4 04/07/10, with diagnoses which included Diabetes, Hypothyroidism, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Arthritis. Review of the MDS admission assessment, dated 04/20/10, revealed Section R of the MDS (R2a section which requires the signature of the RN Assessment Coordinator) had not been signed by a Registered Nurse (RN) Coordinator certifying completion, but had been signed by the Licensed Practical Nurse (LPN). Interview with RN #3, on 04/22/10 at 11:10 AM, revealed that she was not aware that an RN had to sign Section R2a. Interview with LPN #1, on 04/22/10 at 12:30 PM, revealed that she was not aware that an LPN could not sign Section R2a for completion.	F 278	F278 On April 22, 2010 following the Survey the MDS RN and MDS LPN reviewed the regulations and MDS form to ensure that both nurses understood that the MDS required a RN signature. All MDS forms for current Residents were reviewed. No other LPN signature was found. Resident #7 MDS was signed by the MDS RN. All MDS forms will be signed by the RN on completion. The Administrator will monitor compliance on all MDS forms x one month, then randomly x one month. See Attachment B.	6/6/2010
F 281 SS=D	483.20(k)(3)(l) 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 and record review, it was determined the facility failed to provide services to meet professional standards of quality for one (1) of ten (10) sampled residents (Resident #7). The facility failed to follow the physician's order for oxygen administration for Resident #7. The findings include:	F 281		

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F 281	<p>Continued From page 5</p> <p>Observation of Resident #7 on 04/21/10, at 2:00 PM, revealed that resident was in bed with oxygen per nasal canula in place. However, the oxygen appeared to be set on 0 liters. Resident #7 was also receiving a nebulizer treatment.</p> <p>Review of Resident #7's physician orders dated 04/10, revealed an order for oxygen at two (2) liters per nasal canula to keep the oxygen saturations (sats) greater than 90%.</p> <p>Observation at 3:00 PM on 04/21/10, revealed Resident #7, ambulating in the hallway to therapy, with a walker and a Physical Therapist. Further observation of Resident #7 had a nasal canula in place connected to a portable oxygen tank. Resident #7 stated "I'm dizzy". The Physical Therapist assisted the resident to sit in a chair and checked the resident's oxygen saturation, which was 89%.</p> <p>Interview with the Physical Therapist, on 04/21/10, at 3:00 PM, revealed that she had disconnected the nasal cannula tubing from the extension tubing to connect to the portable oxygen tank. The Physical Therapist then went to Resident #7's room, with this surveyor and verified that the oxygen control was not set on 2 liters, she further stated "I did not touch the oxygen control".</p> <p>Interview with Licensed Practical Nurse #2, on 04/21/10 at 3:00 PM, revealed that she was Resident #7's nurse, and that she had given Resident #7's nebulizer treatment about 2:00 PM. Interview further revealed the oxygen was on 2 liters at that time. She further stated, "I do not know who turned the neb (nebulizer) treatment off, but when I went by the resident's room about</p>	F 281	<p>F281 Resident #7's oxygen was reset to 2 liters and resident checked to determine that resident's O2 sat was greater than 90%.</p> <p>Nursing staff rein-serviced on May 10, 2010 and therapy staff on May 13, 2010 on procedure regarding checking oxygen setting when resident is returned to room following therapy or a procedure. See Attachment C and D.</p> <p>Administrator will monitor oxygen settings on all residents receiving oxygen x one month, then randomly x one month to ensure that oxygen is reset and remains on setting ordered by physician. See Attachment E.</p>	6/6/2010

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F 281	Continued From page 6 2:40 PM, it was off. Further interview revealed LPN #2 was aware Resident #7's order stated oxygen at 2 liters; however, she stated she did not check the setting of the oxygen after the nebulizer treatment was finished.	F 281		
F 282 SS=D	During Interview with Resident #7, on 04/21/10 at 3:15 PM, the resident stated "I feel much better I'm not dizzy now with my O2 (oxygen) on". 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to follow the Comprehensive Plan of Care for one (1) of ten (10) sampled residents (Resident #7). The facility failed to ensure that Resident #7's bed/chair alarm was attached as care planned. The findings include: Review of the clinical record revealed Resident #7 was admitted to the facility on 04/07/10, with diagnoses which included Coronary artery disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Diabetes, Hypothyroidism, and Arthritis. Review of Resident #7's care plan revealed the Fall care plan had been initiated on 04/07/10, and revised on 04/19/10 to include intervention of a	F 282	F282 Resident #7's bed alarm was not attached when resident returned from therapy in accordance with the resident's care plan. The resident had been in his room approximately 10-15 minutes when the CNA was made aware of the bed alarm and he attached it. Nursing staff re-in-serviced on May 10, 2010 and therapy staff on May 13, 2010 on procedure regarding the reattachment of the bed alarm and ensuring that the alarm is on when resident is returned to room following therapy, shower or a procedure. See Attachment C and D. Administrator will monitor bed alarms on all residents to ensure that the bed/chair alarm is attached and turned on x one month, then randomly x one See Attachment F.	6/6/2010

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F 282	<p>Continued From page 7 bed/chair alarm.</p> <p>Observation of Resident #7, on 04/21/10 at 2:00 PM and 4:00 PM, revealed the resident laying in bed with a personal alarm attached to bed rail, but not attached to the resident. Observation of Resident #7, on 04/22/10 at 9:00 AM, revealed the resident sitting on the side of the bed with personal alarm attached to the bed rail, but not attached to the resident.</p> <p>Interview with the Physical Therapist on 04/21/10 at 4:20 PM, revealed she had assisted Resident #7 back to bed and had not attached the alarm to the resident. She further stated "I usually always make sure alarms are attached to residents, that would be my mistake".</p> <p>Interview with State Registered Nurse Aide (SRNA) #1, on 04/21/10 at 4:15 PM, revealed that Resident #7 was in therapy when he came on duty. He further stated the resident had been back in the room about 10 to 15 minutes, however, he had not been in the resident's room to check on the resident. SRNA #1 stated that he checks residents about every 1 to 1 1/2 hours for alarm placement. SRNA #1 went to Resident #7's room with this surveyor and verified that the alarm was not attached to the resident, he stated "we encourage therapy to put alarms on before they leave a resident".</p>	F 282		

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<p>K 000</p> <p>K 052 SS=F</p>	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was initiated and concluded on 04-20-2010 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest Scope and Severity of an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain its fire alarm according to NFPA standards.</p> <p>The findings include:</p> <p>During observations on 04-20-10 at 12:36 PM, the testing of the fire alarm control panel dialers revealed that the fire alarm company did not</p>	<p>K 000</p> <p>K 052</p>	<p>Please accept this Plan of Correction as the St. Luke Hospital East Skilled Nursing Facility's credible allegation of substantial compliance effective June 6, 2010 for the deficiencies noted from the survey completed April 22, 2010. It is our intent that we have substantially corrected our deficiencies per requirements in 42 CFR Part 483 subpart B.</p> <p>K052 The facility ensures the safety of its patients through its policies and practices related to the installation, maintenance and testing of the fire alarm system.</p> <p>On 4/23/2010 a work order was issued for the installation of two control points for the fire alarm. Attachment K1. In the event there is trouble with the fire alarm phone lines the alarm would be sent to the PBX monitoring office. The PBX office is monitored 24/7 and staff have direct communication with the security staff. The installation of the alarm points will ensure that any problem will be reported within the established 4 minute period. The points will be installed on May 14,2010.</p>	<p>6/6/10</p>
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MAY 17 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wendy Bauer NHA Administrator</i>	TITLE <i>Administrator</i>	(X8) DATE <i>5/14/10</i>
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K 052	<p>Continued From page 1</p> <p>respond to the pulled telephone line trouble signal. When maintenance called the alarm company it reported that the disconnected telephones lines were a trouble signal, and their company policy was to call within four (4) hours.</p> <p>Actual NFPA Standard: Reference: NFPA 72 1999 edition</p> <p>1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated.</p> <p>1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes</p>	K 052		

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K 052	<p>Continued From page 2</p> <p>from receipt of a trouble signal by the central station until initiation of the investigation by telephone.</p> <p>5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1:</p> <p>(1) Both channels shall be supervised in a manner approved for the means of transmission employed.</p> <p>(3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes.</p> <p>(8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p> <p>3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as stand alone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance.</p>	K 052		