

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

PRINTED: 08/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	<div style="border: 2px solid black; padding: 5px; text-align: center;"> RECEIVED AUG 17 2011 07/27/2011 Division of Health Care Southern Enforcement Branch </div>	
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>A standard and extended health survey was initiated on 06/21/11, and concluded on 06/29/11. Immediate Jeopardy was identified on 06/23/11, and determined to exist on 06/17/11. The facility was notified on 06/23/11. Resident #14 had a living will and a physician's order for Cardiopulmonary Resuscitation (CPR) "only" to be administered. Resident #14 was identified to have a change in condition with an abnormal blood pressure reading of 86/30 and a heart rate of 40 on 06/17/11, at 8:00 PM. However, there was no documented evidence facility staff notified the resident's physician, or monitored and assessed Resident #14 for further changes in vital signs or physical condition. On 06/18/11, at 3:55 AM, the resident was found unresponsive, not breathing, and with no signs of life. Facility staff was unaware of Resident #14's code status for "CPR only" and failed to discuss CPR administration with the physician when the physician was informed of the resident's condition. Resident #14 expired at the facility on 06/18/11. Deficiencies were cited at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.25 Quality of Care (F309), and 42 CFR 483.75 Administration (F490) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F309).</p> <p>After State Agency review the survey was reopened on 07/26/11, to obtain additional information, and concluded on 07/27/11.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 06/29/11, and an amended AOC was received on 07/27/11, which alleged removal of Immediate Jeopardy on 06/29/11.</p>	F 000			

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

Judy Perry

TITLE

Administrator

(X5) DATE

08/17/11

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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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314	
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F 000	Continued From page 1	F 000		
F 157 SS-J	<p>483.10(F157), 42 CFR 483.25 (F309), and 42 CFR 483.75 (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <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>	F 157	<p>Preparation and execution of this plan of</p> <p>Correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p>F 157 J (D) NOTIFY OF CHANGES</p> <p><i>Residents Found to Have Been Affected</i> Resident #14 is no longer in the facility. Counseling and education was provided to LPN #1; however, she is no longer employed at the center.</p>	

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F 157	<p>Continued From page 2</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 interview, record review, and facility policy review it was determined the facility failed to have an effective system to ensure the resident's physician was notified when a significant change in physical status occurred for one of twenty-three sampled residents (Resident #14). On 06/17/11, at 8:00 PM, facility staff assessed Resident #14 to have an abnormally low blood pressure and pulse rate. Facility staff failed to report the abnormal findings to Resident #14's attending physician at the time of the assessment. Approximately eight hours later, the resident was found by direct care staff to be nonresponsive and without any signs of life. Resident #14 was pronounced dead on 06/18/11, at 4:15 AM, by the coroner. The facility's failure to promptly inform Resident #14's attending physician regarding a significant change in condition placed Resident #14 and other residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 06/17/11.</p> <p>An acceptable Allegation of Compliance was received on 06/29/11, and an amended AOC was received on 07/27/11, which alleged removal of Immediate Jeopardy on 06/29/11. The State Agency determined the Immediate Jeopardy was removed on 06/29/11, which lowered the scope and severity to "D" while the facility monitors the effectiveness of systemic changes and quality</p>	F 157	<p><i>Identification of Other Residents with the Potential to be Affected</i></p> <p>A thorough review of medical records was conducted by the Executive Director of Nursing (EDON), Director of Nursing (DON), Quality Assurance Nurse, MDS Coordinators, Medical Records Director, and Unit Managers for all residents in the center beginning on 6/25/2011. Reviews were completed to identify any changes in resident's condition that would constitute notification of physician and/or responsible party. If a change in condition was indicated, the resident was assessed further at that time and notification was made to physicians and/or responsible parties as indicated.</p> <p><i>Systemic Changes</i></p> <p>All licensed nurses were inserviced by the EDON and DON regarding facility policy and procedure on notification requirements related to change in condition, family/resident/physician notification, assessment, follow up and documentation of change in resident condition. Inservices were conducted on 6/27/2011 and 6/28/2011. Any licensed nursing staff having not attended the inservice by 6/28/2011, will be required to attend the inservice prior to being permitted to work. Family and Physician Notification</p>	

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F 157	<p>Continued From page 3 assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure related to physician notification (dated December 2007) revealed facility staff was responsible to promptly notify the attending physician of changes in a resident's medical/mental condition. According to the policy, nursing supervisors/charge nurses were required to notify a resident's attending physician or on-call physician when a significant change occurred in a resident's physical/emotional/mental condition, when a change in baseline vital signs occurred, or when a need to alter a resident's medical treatment significantly had been identified.</p> <p>A closed record review revealed Resident #14 was admitted to the facility on 03/09/10, with diagnoses to include Hypertension, Alzheimer's Dementia, and Encephalopathy.</p> <p>A review of the current physician's orders dated 06/06/11, revealed Resident #14 was prescribed Lisinopril (antihypertensive) 40 milligrams (mg) once daily and Toprol XL (antihypertensive) 25 mg ER twice a day for treatment of Hypertension. Further record review from 05/18/11 through 06/15/11, revealed Resident #14's blood pressure ranged from 124/68 to 110/64, and the resident's heart rate ranged from 76-84 beats per minute.</p> <p>A review of the progress notes dated 06/17/11, at 8:00 PM, revealed Licensed Practical Nurse (LPN) #1 attempted to administer medications to Resident #14, but was unable to administer the medications due to the resident's refusal to open</p>	F 157	<p>will be included in the Orientation Process for all new hires.</p> <p>The 72 Hour Charting Policy and form were implemented on 06/28/2011. The purpose of this policy and form is to identify, report, and assess a change in resident condition. Licensed nurses were inserviced by the EDON, DON, and Unit Managers on the 72 Hour Charting Form and Policy on 6/27/2011 and 6/28/2011. The licensed nurses are responsible for assessing the change in resident condition, notifying the resident/family and physician as appropriate, and implementing interventions as necessary.</p> <p>Beginning 06/28/2011, a daily review of all current residents' MD orders, Care Plan Updates, Condition Change Forms, 72 Hour Charting Forms, and the 24-Hour Report is completed by the DON, Quality Assurance Nurse, Medical Records Director, and/or Unit Managers to validate physician and family notification of change. If notification was indicated, the resident was further assessed and notification was made as appropriate at the time identified.</p>	

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F 157	<p>Continued From page 4</p> <p>his/her mouth. At that time, according to the progress notes, LPN #1 obtained the resident's vital signs and documented the resident had a blood pressure of 86/30 and a heart rate of 40. However, there was no documented evidence LPN #1 notified the resident's attending physician of the abnormal vital signs and change in the resident's condition. Further review of the progress notes revealed on 06/18/11, at 3:55 AM, LPN #1 was called to Resident #14's room after direct care staff discovered the resident to be unresponsive and not breathing. Record review revealed LPN #1 assessed and noted the resident's legs and feet were cold and discolored, the resident's hands were cool to touch, and the resident's skin color was pale. LPN #1 documented Resident #14 had no "signs of life" with no obtainable blood pressure, heart rate, or respirations.</p> <p>An interview conducted with LPN #1 on 06/23/11, at 4:25 PM, revealed the LPN worked part-time during the 7:00 PM to 7:00 AM shift at the facility. LPN #1 stated she had obtained Resident #14's blood pressure and heart rate at 8:00 PM on 06/17/11. The LPN stated she did not know what Resident #14's blood pressure and heart rate usually were and did not compare the resident's blood pressure and heart rate to the resident's vital sign record. LPN #1 further stated she considered a blood pressure of 86/30, and a heart rate of 40 to be abnormal for "anyone." The LPN stated she did not notify the resident's attending physician of the resident's abnormal vital signs at the time they were obtained.</p> <p>An interview with Resident's #14's attending physician (MD #1) on 06/23/11, at 6:30 PM,</p>	F 157	<p>Monitoring</p> <p>To ensure sustained compliance, DON, and the Quality Assurance Nurse are responsible to report all audit findings to the Administrator and the Quality Assurance (QA) Committee weekly until compliance is achieved, then monthly for three months and as needed thereafter, for review. The standing members of the Quality Assurance Committee include the Administrator, DON, Unit Managers, Quality Assurance Nurse, Medical Records Director, and Medical Director.</p>	8/15/2011	

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F 157	<p>Continued From page 5</p> <p>revealed she would have expected facility staff to report changes in the resident's condition and vital signs to her. MD #1 stated the resident's systolic (top number of a blood pressure reading) blood pressure usually was 100-110 and his/her heart rate of 40 would have been "alarming" to her. MD #1 further stated she would have considered sending Resident #14 to the Emergency Room for further evaluation/treatment, or at least considered intravenous therapy to increase the resident's blood pressure, if she had been made aware of the changes in Resident #14's condition.</p> <p>An interview conducted with the Director of Nursing (DON) on 06/23/11, at 8:15 PM, revealed the nurse was responsible to notify a resident's physician when a change in condition was identified. The DON stated LPN #1 should have informed Resident #14's attending physician about a change in blood pressure and heart rate on 06/17/11, at 8:00 PM.</p> <p>*An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was received on 06/29/11, and an amended AOC was received on 07/27/11, which alleged the Immediate Jeopardy was removed on 06/29/11.</p> <p>According to the AOC, a thorough review of all residents' medical records was conducted by the Executive Director of Nursing (EDON), Director of Nursing (DON), Quality Assurance Nurse (QAN), MDS Coordinators, Medical Records Director, Registered Nurse (RN) and all Unit Managers (UMs) on 06/25/11, 06/26/11, 06/27/11, and 06/28/11. The reviews were conducted to identify changes in residents' condition that would require</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>notification of the resident's physician and/or responsible party. If a change in condition was identified as a result of the record review, facility staff was to further assess the resident's condition and make notifications to the physicians and/or legal representatives/interested family members as indicated.</p> <p>Further review of the AOC revealed on 06/28/11, the facility began a daily review of all residents' current physician's orders, care plan updates, condition change forms, and the 24-hour report. The daily reviews were to be completed by the EDON, DON, QAN, Medical Records Director, and/or UM to determine and ensure significant changes in a resident's condition had been immediately reported to the resident's physician and family member/legal representative. In addition, the daily reviews were to determine if continued assessment of a resident's condition was indicated and to determine if resident assessments were made in a timely manner.</p> <p>The AOC revealed on 05/27/11 and 06/28/11, all licensed nurses were in-serviced by the EDON, DON, QAN, and UM related to the facility's policy and procedure on notification of the resident's physician and family when changes in the resident's condition occur. The AOC also revealed all licensed nurses were in-serviced on resident assessment, follow-up assessments, and documentation of changes in resident condition. Licensed nursing staff who had not attended the in-service by 06/28/11, would be required to attend the in-service prior to being permitted to work. Continued review of the AOC revealed the above information would be included in the Orientation Process for all newly hired staff.</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>A review of the AOC revealed on 06/28/11, the facility implemented a 72 Hour Charting Policy and charting form. Facility staff was to utilize the policy and forms to identify, report, and assess residents for a change in condition. Licensed nurses were in-serviced by the EDON, DON, QAN, and Unit Managers on 06/27/11 and 06/28/11, on the 72 Hour Charting Policy and charting form. These forms were to be reviewed daily by the EDON, DON, QAN, Unit Managers, or a designated licensed nurse to ensure appropriate notification occurred.</p> <p>Review of the AOC revealed the facility was to ensure continued compliance by reporting all audit findings to members of the Quality Assurance (QA) Committee on a weekly basis until compliance was achieved, and then on a monthly basis for three months to ensure continued compliance. Following the submission of the monthly reports for three months, staff was to continue to submit findings on an as needed basis for review, to ensure sustained compliance. The AOC revealed the Administrator was responsible for overall compliance through attendance of the Clinical Meetings, by directing and oversight of the QA Meeting, and reviewing all audits.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>A review of the facility's audits on 06/29/11, verified the facility completed a thorough review of all residents' medical records.</p> <p>A review of sign-in sheets and interviews with</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>staff (RNs #3, #4, #5, #6, #7, and #8 and LPNs #2, #3, #4, #5, and #6) on 06/29/11, verified the facility had in-serviced nursing staff on 06/27/11 and 06/28/11, related to the identification and assessment of changes in resident conditions, notification of changes to physicians and responsible parties, and the 24-hour reports and 72-hour charting policy and form. In addition, according to observations and interviews with staff (RNs #3, #4, and #7 and LPNs #3, #4, and #6) on 06/29/11, the 24 and 72-hour monitoring records were kept at the nurses' stations and monitored daily by the administrative staff (Administrator, EDON, DON, MDS Coordinators, UMs, and QAN).</p> <p>An interview with the Director of Nursing (DON) on 06/29/11, at 6:10 PM, and record review verified the 24 and 72-hour reports, utilized to monitor residents for changes in condition, were reviewed daily in the Daily Clinical Meeting, and any concerns were addressed and acted upon at that time.</p> <p>An interview with the Administrator on 06/29/11, at 7:35 PM, verified administrative staff (Administrator, EDON, DON, MDS Coordinators, UMs, and QAN) reviewed the 24 and 72-hour reports daily in the Daily Clinical Meeting, to ensure concerns observed with changes in resident condition and/or physician notification would have immediate correction.</p> <p>Based on the above findings, it was determined the Immediate Jeopardy was removed on 06/29/11. Noncompliance continued with the scope and severity lowered to "D" based on the need for the facility to evaluate and implement</p>	F 157			

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F 157	Continued From page 9 systematic changes and quality assurance activities.	F 157		
F 253 SS-E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and record review, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment. Forty-two doors were observed to have chipped wood and tan putty on them, three resident rooms were observed to have a blackened substance on the floor tile, one resident room was observed to have a brown discolored area on the floor, one resident room was observed to have peeling wallpaper, and one resident room was observed to have peeling paint. The findings include: A review of the facility's policy entitled "Housekeeping Policy" (no date) revealed the Housekeeping Department was responsible to report any unusual condition or mechanical failure to the Maintenance or Housekeeping Supervisor. The facility was asked for a Maintenance Policy and none was received.	F 253	<u>F 253 (E) HOUSEKEEPING AND MAINTENANCE SERVICES</u> <i>Residents Found to Have Been Affected</i> -New doors have been selected and ordered for resident rooms: 104, 106, 107, 108, 109, 110, 111, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, and 222. -The floor tile noted with a blackened substance (tile adhesive) has been removed from rooms 104, 210, and 221. -The brown discolored area observed on floor tile in resident room 108 has been removed. -The peeling wallpaper observed above the beds in resident room 214 has been removed and the room has been freshly painted. -The peeling paint observed on the wall on the left side of the bathroom door in resident room 203 has been removed and the room has been freshly painted. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected. New doors have been selected and ordered for all resident rooms. All resident rooms have been reviewed to identify any peeling paint, peeling wallpaper, and discolored flooring or flooring with any unsightly substance.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2011
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 280 BOONEVILLE, KY 41314		
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F 253	Continued From page 10 During the environmental tour of the facility on 06/23/11, at 3:15 PM, the following items were observed to be in need of repair: -Chipped wood and tan putty were observed on resident room doors in resident rooms 104, 106, 107, 108, 109, 110, 111, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, and 222. -A blackened substance was observed on the floor tile in resident rooms 104, 210, and 221. -A brown discolored area was observed on the floor tile in resident room 108. -Peeling wallpaper was observed above the beds in resident room 214. -Peeling paint was observed on the wall, on the left side of the bathroom door, in resident room 203. An interview was conducted with the Housekeeping Supervisor (HS) and a Maintenance Representative (MR) on 06/23/11, at 3:15 PM. The Maintenance Supervisor was on vacation and not available for interview. The MR stated the facility utilized a work order system to alert maintenance staff of concerns related to the environment. The MR stated the employees tape the work order to the Maintenance Department door or slide it under the door. The HS stated she conducted a tour on a daily basis to observe for cleanliness on each nursing unit. Based on interview with the HS, if any concerns related to maintenance of the facility were identified during the tour, a report would be submitted to the Maintenance Department.	F 253	Systemic Changes The Administrator has developed a new maintenance policy that includes monthly inspection rounds by the maintenance and housekeeping supervisors. The inspection process will check condition of doors, walls and floors. A door replacement plan has been developed by the Administrator to include new doors and new hardware. Ordering and installation schedules are part of the door replacement plan. After all new doors have been installed the maintenance department will make physical rounds monthly for the purpose of inspecting all doors. Any repairs or replacement of doors will be made within fifteen days of the observations made on the monthly inspection report made by the Maintenance Supervisor. Monitoring The Administrator will review the monthly report which includes the facility doors, walls and floors with the maintenance and housekeeping supervisors. A follow-up will be completed by the Administrator to ascertain that repairs and replacements were completed within fifteen days.	8/15/2011	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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F 281 SS=D	<p>Continued From page 11</p> <p>PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of facility policies, it was determined the facility failed to provide services to meet professional standards of quality related to staff orientation and training for one employee. The facility failed to have an effective system to provide orientation and training for new employees and to evaluate for staff competency. Licensed Practical Nurse (LPN) #1 was hired by the facility on 05/17/11; however, there was no evidence the facility had provided the LPN with appropriate training related to facility policy/procedures regarding Advance Directives and Code Status.</p> <p>The findings include:</p> <p>A review of the Staff Orientation and Education policy/procedures (no date) revealed the facility would provide comprehensive orientation to newly hired employees and provide ongoing education to current employees. The policy/procedures stated new employees would begin orientation on the first day of employment and would include classroom instruction and hands-on specific job training. The policy/procedures further identified staff would receive training on facility policies/procedures and systems related to their individual job requirements.</p> <p>A review of the personnel file for LPN #1 revealed</p>	F 281	<p><u>F281 (D) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u></p> <p><i>Residents Found to Have Been Affected</i></p> <p>No residents were identified as being affected in this deficiency. LPN #1 is no longer employed by the facility.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i></p> <p>All residents have the potential to be affected. All nursing staff have been in serviced on the facility's policy and procedure for Advance Directives and identification of code status.</p> <p><i>Systemic Changes</i></p> <p>A comprehensive orientation agenda and checklist has been developed for new employees to ensure education is provided and comprehension is measured regarding the facility's policies and procedures including Advance Directives and identification of code status. All nursing staff will received mandatory bi-annual training on the facility's policy and procedure for Advance Directives and identification of code status as part of the routine in-service calendar.</p> <p><i>Monitoring</i></p> <p>Post tests have been developed to evaluate the effectiveness of orientation. The results of the post tests will be evaluated by the QA Nurse and/or DON for trends and submitted to the QA Committee meeting for further review and recommendations as indicated. New hires will be re-evaluated within 3 months of</p>	

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F 281	<p>Continued From page 12</p> <p>the nurse was hired by the facility on 05/17/11. According to the orientation checklist dated 05/17/11, LPN #1 received general orientation on Business Office procedures, General/Human Resources, Environment, Social Services, Safety, and Infection Control. However, there was no evidence the facility provided LPN #1 with orientation/training regarding established facility policies/procedures.</p> <p>An interview conducted with LPN #1 on 06/23/11, at 4:25 PM, and on 07/27/11, at 2:20 PM, revealed the LPN had been a nurse for more than 20 years and had been employed by the facility for approximately two months to work part-time on the 7:00 PM to 7:00 AM shift. LPN #1 stated she had been assigned to work with four different licensed nurses for four shifts on the 7:00 PM to 7:00 AM shift for orientation. The LPN stated neither of these nurses instructed her on the Advance Directive and/or Code Status facility protocols and the LPN did not know how to identify a resident's code status. LPN #1 further stated an in-service on Advance Directives was provided by the facility after she was employed, but the LPN did not attend the in-service because she did not know it was scheduled. LPN #1 also stated she did not inform the administrative staff that she needed additional training.</p> <p>A review of the June 2011 staffing schedule revealed LPN #1 was scheduled to work the 7:00 PM to 7:00 AM shift on a part-time basis each Friday and Saturday on the East Wing. According to the staffing schedule the LPN was usually scheduled to work as the charge nurse with a Certified Medication Aide (CMA). The staffing schedule further revealed two licensed</p>	F 281	hire date by additional post testing to ensure competency and retained comprehension of education received.	8/15/2011	

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F 281	<p>Continued From page 13</p> <p>nurses were also scheduled to work on the West Wing of the facility during the 7:00 PM to 7:00 AM shift.</p> <p>An interview conducted with LPN #7 on 07/26/11, at 1:25 PM, revealed the LPN had been assigned to work with LPN #1 during one 7:00 PM to 7:00 AM shift. LPN #7 stated she did not receive any directions regarding specific training for new staff. The LPN stated she instructed LPN #1 regarding the medication pass, shift routine, and residents, but did not inform LPN #1 about the facility policies/procedures related to Advance Directives or Code Status. LPN #7 further stated the training was not documented.</p> <p>Interview conducted with Registered Nurse (RN) #9 on 07/26/11, at 1:45 PM, revealed she had worked with LPN #1 on one 7:00 PM to 7:00 AM shift. The RN stated she did not receive any directions regarding training needs for LPN #1. RN #9 stated she instructed LPN #1 on the medication pass, location, and procedures for the crash cart, and content of residents' charts, including the location of the Advance Directive and Code Status. RN #9 stated she could not recall telling LPN #1 about any other means of identification to determine the residents' Code Status. The RN stated she did not document the training provided for LPN #1.</p> <p>LPN #8 was interviewed on 07/26/11, at 5:55 PM, and stated she had worked one 7:00 PM to 7:00 AM shift with LPN #1. The LPN stated she told LPN #1 about the medication pass and charting protocol. LPN #8 stated she also informed LPN #1 the red stripe located on the binder of the resident's chart identified the resident to be a Do</p>	F 281			

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F 281	<p>Continued From page 14</p> <p>Not Resuscitate (DNR). The LPN stated she did not provide any further training for LPN #1 regarding facility policies/procedures related to Advance Directives/Code Status.</p> <p>Interview conducted with the Staff Development Nurse/Executive Director of Nurses (EDON) on 07/26/11, at 6:10 PM, revealed new staff (if experienced) was assigned to work with another experienced nurse for three shifts on each unit after general orientation had been provided. The EDON stated the training nurse was told to orient the new nurse to the routine paperwork, the residents, and facility policies/procedures, including the Advance Directive and Code Status. However, interviews with LPN #7, RN #9, and LPN #8 revealed they had not received direction related to orienting new nurses regarding the facility policies/procedures related to Advance Directives or Code Status.</p> <p>Further interview on 07/26/11, at 6:10 PM, revealed the EDON talked with the assigned training nurse and the new nurse to evaluate the effectiveness of the training to determine if additional training was needed. The EDON further stated a checklist was completed after general orientation was provided. However, the EDON stated there was no documentation of further staff orientation and no documentation the training had been evaluated to determine staff competency. The EDON also stated the facility did not have a policy/procedure related to evaluation of new employee orientation and competency evaluation. In addition, the EDON stated mandatory in-services were conducted monthly and the facility policy directed disciplinary action would be taken if the employee failed to</p>	F 281			

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F 281	Continued From page 15 attend; however, this procedure had not been enforced.	F 281			
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies, it was determined the facility failed to provide services for one of twenty-three sampled residents (Resident #11) in accordance with the resident's individualized plan of care.</p> <p>The findings include:</p> <p>A review of the Plan of Care policy/procedure (no date) revealed the comprehensive care plan would contain approaches to care that would benefit the needs of the resident.</p> <p>Resident #11 was admitted to the facility on 05/19/10, with diagnoses that included Closed Fracture of the Tibia and Fibula, Senile Dementia, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and Convulsions. A review of the significant change Minimum Data Set (MDS) assessment completed on 01/29/11, revealed the facility assessed Resident #11 to require total assistance with bed mobility, toileting, personal hygiene, and bathing. The resident was also assessed to have a Stage II pressure ulcer</p>	F 282	<p><u>F282 (D) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</u></p> <p><i>Residents Found to Have Been Affected</i> Resident #11 has heel boots in place. The C.N.A. that was involved has been counseled and inserviced on following the residents' care plan. <i>Identification of Other Residents with the Potential to be Affected</i> An audit was completed of all residents' comprehensive care plans and SRNA care plans in comparison with a direct observation of care delivery. Audit and observations were made by the DON, Medical Records Director (RN), and MDS Nurses to ensure the care plan interventions are carried out as outlined on the resident's care plan.</p> <p><i>Systemic Changes</i> An inservice was held for nursing staff regarding following resident's care plan, obtaining devices and/or supplies as needed to provide care in accordance with the resident's care plan.</p> <p><i>Monitoring</i> Care rounds will be conducted daily by the facility's management staff, DON, Unit Managers, QA Nurse, and Medical Records Director (RN) to monitor and ensure care are being delivered in accordance with the plan of care. Results of the initial audit and daily care rounds will be submitted to the QA Committee for review and further action if indicated.</p>	8/15/2011	

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F 282	<p>Continued From page 16 present on the sacral area.</p> <p>A review of the comprehensive care plan dated 04/20/11, revealed the facility had identified the resident's alteration in skin integrity. Interventions related to the resident's impaired skin integrity included to turn and reposition the resident every two hours, to use a pressure-relieving mattress on the resident's bed, to provide ulcer care to the area as ordered by the physician, and to "float" the resident's heels with pillows or heel boots/cushions bilaterally.</p> <p>Observations of Resident #11 on 06/23/11, at 9:55 AM and 11:50 AM, revealed no evidence that heel boots or floaters were being used for Resident #11. Further observations during a skin assessment conducted on 06/23/11, at 11:50 AM, revealed the resident's left heel was observed to be reddened but blanchable to touch.</p> <p>An interview conducted with RN #1 on 06/23/11, at 11:55 AM, revealed facility staff had developed a care plan to have heel boots on Resident #11's heels, bilaterally, due to an increased risk for pressure sore development. RN #1 looked in the resident's closet and bedside table for the heel boots, but none were found in the resident's room. The RN obtained heel boots and placed them on Resident #11.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #3 on 06/23/11, at 12:00 PM, revealed the CNA was aware Resident #11 required the use of heel boots or floaters. However, the CNA stated the resident's heel boots had not been available for Resident #11 for "a few days," since the resident's boots were sent to laundry. The CNA</p>	F 282			

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F 282	Continued From page 17 stated she had reported this to the nurse last week and had checked laundry for the boots/floaters, but was unable to locate Resident #11's heel boots. Interview with RN #4, the Unit Manager, on 06/23/11, at 3:20 PM, revealed interventions were added to Certified Nursing Assistant (CNA) care plans, and nurses on the floor were required to review interventions/CNA care plans at the end of each shift and when doing medication rounds. In addition, the Quality Assurance nurse conducted spot checks to ensure care plans were being implemented.	F 282		
F 309 SS-J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to have an effective system to ensure necessary care and services were provided to maintain the physical well-being for one of twenty-three sampled residents (Resident #14). Resident #14 had a living will and a physician's order for Cardiopulmonary Resuscitation (CPR) "only" to be administered. Resident #14 was identified to have a change in condition with an abnormal	F 309	<u>F309 (J) (D) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</u> <i>Residents Found to Have Been Affected</i> Resident # 14 is no longer in the facility. Counseling and education was provided to LPN #1; however, she is no longer employed at the center. <i>Identification of Other Residents with the Potential to be Affected</i> A comprehensive review was conducted by the Clinical Management Staff, Director of Nursing, Quality Assurance Nurse, MDS Coordinators, Medical Records Director, and Unit Managers. The following documents and records were included in the review: The 24 hour report, physician's orders, Resident's Advance Directive and/or code status, Nurse's Notes, Condition Change forms,	

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F 309	<p>Continued From page 18</p> <p>blood pressure reading of 86/30 and a heart rate of 40 on 06/17/11, at 8:00 PM. However, there was no documented evidence facility staff monitored and assessed Resident #14 for further changes in vital signs or physical condition. On 06/18/11, at 3:55 AM, the resident was found unresponsive, not breathing, and with no signs of life. Resident #14 expired at the facility on 06/18/11. Facility staff was not aware of Resident #14's code status of "CPR only" and failed to discuss this with the resident's physician when the physician was informed of the resident's condition.</p> <p>The failure of the facility to ensure care and services to maintain physical well-being was provided placed Resident #14 and other residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 06/17/11.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 06/29/11, and an amended AOC was received on 07/27/11, which alleged removal of Immediate Jeopardy on 06/29/11. The State Agency determined the Immediate Jeopardy was removed on 06/29/11, which lowered the scope and severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Change in Condition Monitoring Assessment policy (no date) revealed the facility nurse was required to conduct an assessment of a resident prior to notifying the resident's physician of a change in the resident's</p>	F 309	<p>and Care Plan Updates. Reviews were completed to identify any changes in resident's condition that would constitute further assessment if indicated. Any resident identified with a change in condition was assessed by a licensed nurse.</p> <p><i>Systemic Changes</i> All licensed nurses were inserviced by the Center Nursing Administration Staff (EDON, DON, UM's, QAN) regarding center policy and procedure on assessment of change in condition, follow up and documentation of assessment change in resident condition, and the facility policy on Advance Directives and identification of code status. The Center's policy on Assessment of Change in condition and Advance Directives and identification of code status will be included in the updated Orientation Process for all new hires. All nursing staff will receive mandatory bi-annual in-service on the facility's policy of Advance Directives and identification of code status. The 72 Hour Charting Policy and form were implemented on 06/28/2011. The purpose of this policy and form is to identify, report, and assess a change in resident condition. Licensed nurses were inserviced by the Center Nursing Administration Staff (EDON, DON, UM's, QAN) on the 72 Hour Charting Form and Policy. The licensed nurse is responsible for assessing the change in resident condition, notifying the resident/family and physician as appropriate, and implementing interventions as necessary.</p>	

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F 309	<p>Continued From page 19</p> <p>condition. The policy further stated the assessment would include vital signs, airway/breathing assessment, circulation, a review of the relevant labs, recent medication changes, and any deviation from the resident's normal findings.</p> <p>A review of the facility's Vital Signs policy/procedure (no date) revealed vital signs would be taken as ordered by the resident's physician. The policy further noted licensed nurses were responsible to use professional judgment to determine when vital signs would be indicated.</p> <p>Review of the facility's Advance Directives/Code Status policy/procedures (dated December 2010) revealed the facility would honor the Advance Directives of each resident in accordance with state law. The policy/procedures stated a resident's code status would be designated in the resident's medical record under the advance directive tab. According to the policy, for a resident who requested "Do Not Resuscitate" (DNR) status, a red strip would be placed on the spina of the medical record and consent would be placed under the advance directive tab of the resident's medical record. The policy/procedure further directed CPR would not be initiated when the resident had orders for DNR, or when obvious signs of death were present. The policy defined the most reliable signs of death to be dependent livido (general bluish discoloration of the skin, as in pooling of blood in dependent body parts), rigor mortis (hardening of muscles or rigidity), algor mortis (cooling of the body), and/or injuries incompatible with life.</p>	F 309	<p>Beginning 06/28/2011, a daily review of all current residents' physician orders, Care Plan Updates, Condition Change Forms, 72 Hour Charting Forms and the 24-Hour Report is completed by the Executive Director of Nursing, Director of Nursing, Quality Assurance Nurse, Medical Records Director, and/or Unit Managers to validate assessments were completed as indicated by licensed staff in the event of a change in condition. Any resident identified with a change in condition will be assessed by a licensed nurse.</p> <p>The DON or a designated Licensed Nurse, approved by the DON will validate daily that assessment and follow up are completed when a change in resident condition is identified through review of the 72 Hour Charting Forms, Care Plan Updates, Condition Change Forms, and the 24-Hour Report. This validation occurs at the Clinical Meeting (Monday through Friday) with the Clinical Management Team; standing meeting members include, but are not limited to: Administrator, DON, UM, MDSCs, and QAN. On Saturday and Sunday, the DON, or a designated Licensed Nurse, approved by the DON (in the absence of the DON) will complete the validation. Any resident identified with a change in condition will be assessed by a licensed nurse.</p> <p>Monitoring To ensure sustained compliance, the DON, and the Quality Assurance Nurse will report all audit findings and post-in-service and orientation testing to members</p>		

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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 260 BOONEVILLE, KY 41314		
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F 309	<p>Continued From page 20.</p> <p>A closed record review revealed Resident #14 was admitted to the facility with diagnoses to include Hypertension, Alzheimer's Dementia, and Encephalopathy. A review of the Living Will Declaration notarized on 09/10/07, revealed Resident #14 directed no life-prolonging treatment would be provided if the treatment would only serve to artificially prolong the resident's death and also directed the administration of medication or performance of any medical treatment deemed necessary be provided to alleviate pain or for nutrition/hydration. The resident's code status was identified as "CPR only."</p> <p>A review of the medical record revealed Resident #14's blood pressure ranged from 110/64 to 124/68 and the resident's heart rate ranged from 76-84 beats per minute from 05/18/11 to 06/15/11. According to the current physician's orders dated 06/06/11, Resident #14 had orders to receive Lisinopril (antihypertensive) 40 milligram (mg) once daily and Toprol XL (antihypertensive) 25 mg ER twice a day for treatment of Hypertension.</p> <p>A review of the medical record revealed LPN #1 documented in the progress notes on 06/17/11, at 8:00 PM, that Resident #14 refused to take medications as ordered by the physician. The progress notes stated the resident would not open his/her mouth and refused the medications. Further review of the progress notes revealed LPN #1 obtained the resident's blood pressure (86/30) and the resident's heart rate (40). However, there was no further documentation the nurse monitored or assessed Resident #14 for further changes in blood pressure, heart rate, or</p>	F 309	<p>of the Quality Assurance (QA) weekly until compliance is achieved, then monthly for three (3) months and as needed thereafter, for review. This committee reviews the audits and implements any changes needed to sustain compliance. The Administrator is responsible for overall compliance through attendance at the Clinical Meetings, by chairing the QA Meeting, and by reviewing audits.</p>	8/15/2011	

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F 309	<p>Continued From page 21</p> <p>overall physical condition. According to the progress notes, direct care staff reported to LPN #1 on 06/18/11, at 3:55 AM, that Resident #14 was nonresponsive and not breathing. LPN #1 noted in the progress notes that Resident #14's legs and feet were cold and discolored, his/her hands were cool to touch, vital signs could not be obtained, and there were no signs of life.</p> <p>An interview conducted with LPN #1 on 06/23/11, at 4:25 PM, revealed the LPN had obtained Resident #14's blood pressure and heart rate at 8:00 PM on 06/17/11. The LPN stated she did not know what Resident #14's blood pressure and heart rate usually were and did not compare the blood pressure and heart rate to the resident's vital sign record. LPN #1 further stated she considered the blood pressure (86/30) and the heart rate (40) to be abnormal for "anyone." The LPN stated she did see Resident #14 again at 9:00 PM on 06/17/11, and at approximately 12:00 AM on 06/18/11, and Resident #14 was responsive to touch and there were no visible signs of change in the resident's condition. However, LPN #1 stated she did not recheck the resident's blood pressure and heart rate or do a physical assessment of the resident after 8:00 PM on 06/17/11. The LPN further stated she had been trained to recheck a resident's vital signs and to assess/monitor the resident for further changes in physical condition when an abnormal vital sign reading was obtained. However, LPN #1 stated she did not recheck Resident #14's vital signs because she did not see any "visible" changes in the resident. In addition, LPN #1 stated she could not recall a specific training being provided regarding facility policies for identification of a resident's code status and was</p>	F 309			

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F 309	<p>Continued From page 22</p> <p>not familiar with Resident #14's order for "CPR only" to be administered. LPN #1 stated she believed the resident was a DNR and did not believe CPR would have been effective for Resident #14. However, the LPN did not discuss the CPR order with the resident's physician when the physician was informed of the resident's condition at 4:10 AM on 06/18/11.</p> <p>An interview conducted with Certified Nursing Assistant (CNA) #1 and CNA #2 on 06/23/11, at 5:35 PM, revealed CNA #1 and CNA #2 conducted a bed check at approximately 11:00 PM on 06/17/11. CNA #1 stated he observed Resident #14 to be less responsive than the night before when the CNA provided care for the resident. CNA #1 also stated he reported this information to LPN #1 and the nurse directed the CNAs to offer the resident fluids during each bed check. CNA #2 stated she and CNA #1 provided incontinence care for Resident #14 at approximately 1:15 AM on 06/18/11, and observed that the resident continued to respond poorly with no visible signs of respiratory difficulty. CNA #2 stated at approximately 3:50 AM, CNAs #1 and #2 went into Resident #14's room to provide incontinence care during a routine bed check and observed the resident to be cold to touch with blue discoloration from the resident's feet to the trunk area of the resident's body. The CNAs stated they immediately reported the resident's condition to LPN #1.</p> <p>An interview conducted with the Director of Nursing (DON) on 06/23/11, at 8:15 PM, and on 07/26/11, at 5:20 PM, revealed the nurse was responsible to conduct a head to toe physical assessment, which included an evaluation of all</p>	F 309		

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F 309	<p>Continued From page 23</p> <p>body systems, and to document the assessment information in the progress notes when a change in a resident's condition occurred. The DON stated the nurse was also responsible to conduct and document ongoing assessment/monitoring of a resident's condition to evaluate for further changes in the resident's condition. The DON also stated the nurse was responsible to obtain vital signs of the resident at least weekly. In addition, the DON stated the nurse should use good nursing judgment to determine when to recheck a resident's vital signs after a change was noted. The DON further stated LPN #1 should have continued to monitor Resident #14's vital signs and to assess the resident for further changes in physical condition. The DON stated although the facility policy directed no CPR would be done if signs of death were present, the nurse should inform the physician of the resident's assessment and follow the directions of the physician.</p> <p>Resident #14's attending physician stated in an interview on 06/23/11, at 6:30 PM, she would have expected facility staff to report changes in the resident's condition and vital signs to her. MD #1 stated the resident's systolic (top number of a blood pressure reading) blood pressure usually was 100-110 and his/her heart rate of 40 would have been "alarming" to her. MD #1 further stated she would have considered sending Resident #14 to the Emergency Room for further evaluation/treatment, or at least considered intravenous therapy to increase the resident's blood pressure, if she had been made aware of the changes in Resident #14's condition. Per interview on 07/26/11, at 4:20 PM, the physician stated facility staff that has been trained in CPR.</p>	F 309			

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F 309	<p>Continued From page 24</p> <p>should be able to make a judgment regarding initiating CPR when a resident has been found to be unresponsive with no signs of life. The physician stated if the resident was assessed to have rigor mortis or to be cold CPR would not be indicated and facility staff should not be required to obtain a physician's order.</p> <p>The Staff Development Nurse/Executive Director of Nurses (EDON) stated in an interview on 07/26/11, at 5:10 PM, the facility did not have procedures in place for new staff to receive the appropriate training to ensure proper code status was followed when a resident was found unresponsive and not breathing. According to the EDON and a review of staff in-service training, mandatory in-services related to Advance Directives were scheduled bi-annually and an in-service had been provided for staff on 06/16/11. LPN #14 did not attend; however, no disciplinary action or retraining had been implemented for LPN #14.</p> <p>*An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was received on 06/29/11, and an amended AOC was received on 07/27/11, which alleged the Immediate Jeopardy was removed on 06/29/11.</p> <p>A review of the AOC revealed a comprehensive review of residents' medical records was conducted by the facility's Clinical Management Staff: Executive Director of Nursing (EDON), Director of Nursing (DON), Quality Assurance Nurse (QAN), Unit Managers (UMs), Medical Records Director, MDS Coordinator RN, and MDS Coordinator LPN. The records and documents reviewed by the Clinical Management</p>	F 309		

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F 309	<p>Continued From page 25</p> <p>Staff were the 24-hour report, physician's orders, nurse's notes, change in condition forms, and care plan updates. The reviews were completed by the facility on 06/25/11, 06/26/11, 06/27/11, and 06/28/11, to identify any changes in resident condition. In addition, a chart audit was conducted on 06/25/11, 06/26/11, and 06/27/11 by the EDON, DON, UMs, and QAN to determine the accuracy of each resident's Advance Directives.</p> <p>The AOC revealed on 06/28/11, the facility began a daily review of residents' physician's orders, care plan updates, condition change forms, and the 24-hour reports. The daily reviews were to be completed by the EDON, DON, QAN, UMs, and/or Medical Records Director to ensure facility staff conducted an assessment of the resident as required, if a change in a resident's condition occurred.</p> <p>The AOC revealed all licensed nurses had attended an in-service on 06/27/11 and 06/28/11, and had been trained on the facility's policy and procedure on assessment of a resident's change in condition, follow-up, and documentation of change in a resident's condition. All licensed staff that had not been in-serviced by 06/28/11, was required to attend an in-service prior to their return to work. In addition, the facility's policy on Assessment of Change in Condition was added to the orientation process for all newly hired employees. The AOC also revealed if the facility utilized staff from a contracted agency, the same above information would be included in the orientation of the contracted employee. The AOC further revealed the facility's policy on Advance Directives was updated on 06/25/11, and</p>	F 309			

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F 309	<p>Continued From page 26</p> <p>in-services for staff were provided on 06/27/11 and 06/28/11, by the EDON, DON, UMs, and QAN regarding the updated policy and procedure for Advance Directives and identification of residents' code status. The AOC noted routine education regarding Advance Directives would continue twice a year per the facility's routine in-service schedule and the Advance Directive/Code Status policy would also be included in the Orientation Process for all new hires.</p> <p>A review of the AOC revealed a 72-hour Charting Policy and form was implemented on 06/28/11. The facility staff was to utilize the policy and form to identify, assess, and report any changes in resident condition to the resident's physician and/or family. Licensed nursing staff was in-serviced on the policy and charting form on 06/27/11 and 06/28/11.</p> <p>The AOC revealed the 72-hour charting forms would be reviewed by the EDON, DON, UMs, QAN, or nurse designated by the EDON, daily in the Clinical Meeting to ensure follow-up assessments were completed if a change in a resident's condition was identified. The AOC further revealed on Saturdays and Sundays the charting forms were to be reviewed by the EDON and/or the DON, or a designated licensed nurse, to ensure changes in a resident's condition had been identified. The AOC included Advance Directive audits would be conducted on ten percent of all resident records weekly for one month and then monthly by the QAN, EDON, DON, UMs, and Medical Director to ensure the policy/procedures on Advance Directives and identification of residents' code status was</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>followed. In addition, the AOC revealed Advance Directives of new admissions would be reviewed in the Clinical Meeting utilizing the Admission Audit tool and staff interviews would be conducted weekly by the QAN, EDON, DON, and UMs to ensure staff's comprehension of the Advance Directive in-services.</p> <p>Further review of the AOC revealed the facility was to ensure continued compliance by reporting all audit findings to members of the Quality Assurance (QA) Committee on a weekly basis until compliance was achieved, then monthly for three months to ensure compliance was maintained, and on an as needed basis thereafter to ensure continued compliance. The QA committee will review audits and implement changes as they are needed to sustain compliance. The Administrator will be responsible for overall compliance and would attend the Clinical Meetings and review audits.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>The facility's documentation reviewed on 06/29/11 and 07/27/11, verified the residents' medical records had been comprehensively reviewed (monitored physician notification, change in status, 24-hour report, 72-hour log, and code status/advance directives) as stated in the facility's AOC.</p> <p>A review of the facility's in-service sign-in sheets and interviews with staff RNs (RNs #3, #4, #5, #6, #7, and #8) and LPNs (LPNs #2, #3, #4, #5, and #6) on 06/29/11, 07/26/11 and 07/27/11, verified staff had been in-serviced on 06/27/11 and</p>	F 309			

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F 309	<p>Continued From page 28</p> <p>06/28/11, as stated in the AOC. Staff further revealed they had been in-serviced to document any change in a resident's condition on the 24-hour record, and to ensure reassessment of the resident would occur. Further interviews with licensed nursing staff (RNs #3, #4, #5, #6, #7, #8, and #9 and LPNs #2, #3, #4, #5, and #6) on 06/29/11, revealed staff had utilized the 24 and 72-hour monitoring records to ensure a change in a resident's condition was identified. In addition, interviews conducted with RNs #3, #4, #5, #7, #8, and #9, LPNs #3, #4, #6, #7, and #8, and Certified Nurse Aides #1, #2, #3, #10, #12, #13, #14, #15, and #16 confirmed staff had been in-serviced regarding Advance Directives and identification of a resident's code status.</p> <p>An interview with the facility's MDS staff on 06/29/11, at 7:00 PM and 7:15 PM, and record review verified all 24 and 72-hour reports were reviewed on a daily basis in the Clinical Meeting. MDS staff stated the reports and resident medical records were reviewed to determine if there had been any changes in a resident's status, incidents, and/or abnormal labs, and if the physician had been notified of the findings. In addition, admission audits were conducted and reviewed in the Clinical Meeting to ensure the resident's Advance Directive information was accurate and available.</p> <p>Interview with the EDON on 06/29/11, at 1:45 PM, revealed nursing staff was to report all significant changes in resident status to her. The EDON stated she would be meeting with Administration daily to report any problems identified through resident record audits and/or any areas of concern identified through the morning Clinical</p>	F 309			

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F 309	Continued From page 29 Meeting. The EDON stated in an interview on 07/27/11, at 4:40 PM, that post tests were being administered to all staff after each mandatory in-service to ensure staff understanding of material provided. Interview with the Administrator on 06/29/11, at 7:35 PM, revealed she would be communicating with the facility's EDON and/or DON daily to be aware of occurrences inside the facility. The Administrator further stated the facility's Nurse Consultant would conduct weekly audits to ensure systems were working properly. Based on the above findings, it was determined the Immediate Jeopardy was removed on 06/29/11. Noncompliance continued with the scope and severity lowered to "D" based on the need for the facility to evaluate and implement systematic changes and quality assurance activities.	F 309			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	<u>F 431 (E) DRUG RECORDS, LABEL/ STORE DRUGS AND BIOLOGICALS</u> <i>Residents Found to Have Been Affected</i> No residents were found to be affected; however, all medication storage areas were audited to ensure vials are dated and stored properly. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2011
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314	
(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 431	<p>Continued From page 30 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and record review, it was determined the facility failed to date all drugs and biologicals in accordance with facility policy and currently accepted professional principles. One vial of Levemir Insulin, one vial of Novolog Insulin, two vials of Novolog Mix 70/30 Insulin, and three vials of Novolin R Insulin were observed opened and available for use; however, the medication was not dated to indicate the date the vials had been opened.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Medication" (no date) revealed nurses were</p>	F 431	<p>Systemic Changes The EDON, DON and Medical Records Director provided inservicing to licensed nurses regarding the center's medication storage policy; dating and initialing vials when opened. Inservices occurred on 7/19/11 through 7/26/11. The Unit Managers will check medication storage areas Monday - Friday of each week and the on-call nurse will check medication storage areas on Saturday and Sunday of each week. The EDON will audit weekly.</p> <p>Monitoring The Unit Managers and DON will submit to the QA Committee weekly for four (4) weeks then monthly thereafter results of the completed audits. The Drug and Biological Report will be utilized for auditing. This report includes opening, dating, and initialing medication vials. The QA Committee will review reports for further recommendations and follow up as needed.</p>	8/15/2011

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F 431	<p>Continued From page 31</p> <p>expected to date and initial insulin vials when opening the vial.</p> <p>Observation on 06/23/11, at 11:00 AM, of the facility's West Wing medication room/carts, revealed one vial of Lantus Insulin in the medication room opened and available for resident use; however, the medication was not dated to indicate the date the vial had been opened.</p> <p>Observation on 06/23/11, at 11:20 AM, of the East Wing medication room/carts, revealed one vial of Novolog Insulin, two vials of Novolog Mix 70/30 Insulin, and three vials of Novolin R Insulin opened and available for resident use; however, the vials were not dated to indicate the date the vials had been opened.</p> <p>An interview conducted on 06/23/11, at 11:30 AM, with the Charge Nurse (CN) for the West Wing Unit of the facility revealed any time a multi-use vial of medication was opened, the nurse was expected to date and initial the vial with the date the vial was opened.</p> <p>An interview with the Unit Manager (UM) for the West Wing of the facility on 06/23/11, at 11:55 AM, revealed the UM monitored all opened vials of medication weekly to ensure all opened vials of medications had been labeled and dated. The UM stated she had not identified any problems related to the vials not being dated.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/23/11, at 12:10 PM. The DON stated the medications should have been initialed and dated at the time the medication was</p>	F 431			

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F 431	Continued From page 32 opened and that UMs were required to conduct "spot" checks to ensure the vials of medications were labeled and dated properly.	F 431		
F 490 SS-J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, it was determined the facility failed to be administered in a manner that promoted the highest physical well-being for one of twenty-three sampled residents (Resident #14). The facility failed to have an effective system in place to ensure policies and procedures were implemented. The facility's Administration failed to ensure staff assessed and monitored residents when a significant change in a resident's condition was identified. Facility Administration also failed to ensure staff received appropriate training/orientation regarding facility policies/procedures for Advance Directives. In addition, the Administration failed to ensure the resident's attending physician was notified timely regarding significant changes in a resident's condition. On 06/17/11, facility staff identified abnormal vital signs and a change in Resident #14's physical condition. However, facility staff failed to inform the resident's attending physician of the condition	F 490	F 490 (J) (D) ADMINISTRATION <i>Residents Found to Have Been Affected</i> Resident #14 is no longer at the facility. Counseling and education was provided to LPN #1; however, she is no longer employed at the center. <i>Identification of Other Residents with the Potential to be Affected</i> A thorough review of medical records was conducted by the Executive Director of Nursing (EDON), Director of Nursing (DON), Quality Assurance Nurse, MDS Coordinators, Medical Records Director, and Unit Managers for all residents in the center beginning on 6/25/2011. Reviews were completed to identify any changes in resident's condition that would constitute notification of physician and/or responsible party and to identify resident's Advance directive and/or code status. If a change in condition was indicated, the resident was assessed further at that time and notification was made to physicians and/or responsible parties as indicated. A Quality Assurance (QA) Committee Meeting was held on 6/28/2011 to review the initial audit of medical records. <i>Systemic Changes</i> A Quality Assurance (QA) Committee Meeting was held on 6/28/2011 to review	

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F 490	<p>Continued From page 33</p> <p>change and failed to assess and monitor Resident #14 for further changes. On 06/18/11, facility staff found Resident #14 unresponsive with no signs of life. Resident #14 expired on 06/18/11. (Refer to F157 and F309.)</p> <p>These facility failures placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 06/17/11.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 06/29/11, and an amended AOC was received on 07/27/11, which alleged removal of Immediate Jeopardy on 06/29/11. The State Agency determined the Immediate Jeopardy was removed on 08/29/11, which lowered the scope and severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Change in Condition Monitoring Assessment policy (no date) revealed the facility nurse was required to conduct an assessment of a resident prior to notifying the resident's physician of a change in the resident's condition. The policy further stated the assessment would include vital signs, airway/breathing assessment, circulation, a review of the relevant labs, recent medication changes, and any deviation from the resident's normal findings.</p> <p>A review of the facility's Vital Signs policy/procedures (no date) revealed vital signs would be taken as ordered by the resident's</p>	F 490	<p>the center's Allegation of Compliance and initial audit results. Compliance with the center's allegation of compliance will be monitored by the Administrator through daily communication with the EDON and/or DON to discuss reviews and/or audits of the following:</p> <ul style="list-style-type: none"> • Physician's Orders • 24 Hour Report • Care Plan Updates • Condition Change Forms • 72 Hour Charting Forms • Clinical Meeting Minutes <p>Results of the reviews and/or audits are submitted to The QA Committee for evaluation of the need for additional interventions if necessary. The Committee will validate implementation of the Credible Allegation of Compliance by:</p> <ul style="list-style-type: none"> • Discussing areas of concern identified in relation to notification of resident change to physician/responsible party in resident condition through audit results and any concerns identified by any QA Committee member. • Meeting weekly or more often as necessary until the center has demonstrated sustained compliance with the corrective actions described in this Credible 		

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F 490	<p>Continued From page 34</p> <p>physician. The policy further noted licensed nurses were responsible to use professional judgment to determine when vital signs would be indicated.</p> <p>A review of the facility's policy/procedure related to physician notification (dated December 2007) revealed facility staff was responsible to promptly notify the attending physician of changes in a resident's medical/mental condition. According to the policy, nursing supervisors/charge nurses were required to notify a resident's attending physician, or on-call physician, when a significant change occurred in a resident's physical/emotional/mental condition, when a change in baseline vital signs occurred, or when a need to alter a resident's medical treatment significantly had been identified.</p> <p>Review of the facility's Advance Directives/Code Status policy/procedures (dated December 2010) revealed the facility would honor the Advance Directives of each resident in accordance with state law. The policy/procedure stated a resident's code status would be designated in the resident's medical record under the advance directive tab. According to the policy, for a resident who requested "Do Not Resuscitate" (DNR) status, a red strip would be placed on the spine of the medical record and consent would be placed under the advance directive tab of the resident's medical record. The policy/procedure further directed CPR would not be initiated when the resident had orders for DNR, or when obvious signs of death were present. The policy defined the most reliable signs of death to be dependent livido (general bluish discoloration of the skin as in pooling of blood in dependent body parts), rigor</p>	F 490	<p>Allegation of Compliance and Plan of Correction and the Federal Requirements of Participation.</p> <ul style="list-style-type: none"> Tracking and trending audit findings to evaluate implementation and identify areas in need of improvement. <p>A comprehensive orientation agenda and checklist has been developed for new employees to ensure education is provided and comprehension is measured regarding the facility's policies and procedures including Advance Directives, identification of code status condition and identification and notification of change in resident condition. All nursing staff will receive mandatory bi-annual training on the facility's policy and procedure for Advance Directives and identification of code status as part of the routine in-service calendar.</p> <p>Monitoring To monitor sustained compliance, the Quality Assurance Nurse will conduct an assessment of implementation of policies and procedures related to notification of changes, and assessment of change on a monthly basis for three (3) months or until sustained compliance is determined. Implementation will be evaluated by the completion of Process Reviews on 10% of the Center's in-house census weekly. An</p>	

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F 490	<p>Continued From page 35</p> <p>mortis (hardening of muscles or rigidity), algor mortis (cooling of the body), and/or injuries incompatible with life.</p> <p>A review of Resident #14's closed medical record revealed progress notes dated 06/17/11, at 8:00 PM, documenting that Licensed Practical Nurse (LPN) #1 obtained a blood pressure of 86/30 and a heart rate of 40 for Resident #14. However, further review of the progress notes revealed no documented evidence Resident #14 was further assessed or monitored. On 06/18/11, at 3:55 AM, Resident #14 was found to have no vital signs and no signs of life. An interview conducted with LPN #1 on 06/23/11, at 4:25 PM, revealed LPN #1 failed to notify the resident's attending physician about the abnormal vital signs and failed to reevaluate the resident's blood pressure and heart rate. In addition, LPN #1 stated she believed Resident #14 was a DNR and was not aware of a physician's order for "CPR only" for Resident #14. Thus, the LPN did not discuss the CPR order with the resident's physician when the physician was informed of the resident's condition at 4:10 AM on 06/18/11. The LPN further stated she did not believe CPR would have been effective for Resident #14. The LPN stated she did not recall a specific training being provided regarding the facility's policy for identification of a resident's code status.</p> <p>An interview conducted with the Director of Nursing (DON) on 06/23/11, at 8:15 PM, revealed Resident #14's medical record had been reviewed during the clinical meeting on 06/20/11. A problem had been identified with the nurse's failure to notify Resident #14's attending physician timely of the resident's abnormal blood</p>	F 490	<p>external nurse consultant will review audit results weekly and perform an additional audit of one chart per week per unit for three (3) months or until substantial compliance is maintained and make recommendations as needed.</p> <p>Findings of the Process Measures will be reported to the Administrator, EDON, and DON for inclusion in the QA Committee meeting. The results of all center audits and reviews will be reported</p>	8/15/2011

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F 490	<p>Continued From page 36</p> <p>pressure, heart rate, and the change in Resident #14's medical condition, and to identify the resident's code status order of "CPR only." However, the DON stated Facility Administration had not implemented a plan of correction to ensure residents were appropriately assessed when a change in condition occurred and the resident's physician notified timely when a change in a resident's condition occurred.</p> <p>An interview conducted with the facility's Administrator on 06/23/11, at 8:45 PM, revealed Resident #14's death was reported to her on 06/18/11. The Administrator stated she was aware of the concerns related to Resident #14's death and planned to take disciplinary action for LPN #1. The Administrator stated no disciplinary action had been initiated at the time of the interview on 06/23/11. The Administrator further stated no plan of correction had been implemented to ensure established policy/procedures were followed to ensure all residents were assessed appropriately or to ensure the resident's physician was informed timely of changes in a resident's condition.</p> <p>Interview conducted with the Staff Development Nurse/Executive Director of Nurses (EDON) on 07/26/11, at 8:05 PM, revealed mandatory in-services related to the facility's code status policy were provided for staff twice a year. However, there was no evidence the facility monitored to ensure staff attended the mandatory in-services or monitored for staff competency after the in-services were provided.</p> <p>*An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was received</p>	F 490			

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F 490	<p>Continued From page 37</p> <p>on 06/29/11, and an amended AOC was received on 07/27/11, which alleged the Immediate Jeopardy was removed on 06/29/11.</p> <p>Review of the AOC revealed the facility held a Quality Assurance (QA) Committee Meeting on 06/28/11, and the following facility staff members were present: Facility Administrator, Executive Director of Nursing (EDON), Director of Nursing (DON), Unit Managers (UMs), Quality Assurance Nurse (QAN), Medical Records Director, and Medical Director. The AOC revealed all initial audit results of residents' records were reviewed by the committee members during the meeting.</p> <p>The AOC also revealed the facility's compliance would be monitored daily by the Administrator. Further review of the AOC revealed the Administrator would communicate daily with the EDON and/or DON, and discuss the results of the audits of resident physician's orders, 24-hour report, care plan updates, condition change forms, 72-hour charting forms, and the Clinical Meeting Minutes. The results of these findings were to be evaluated by the QA Committee members, and the members were to make interventions as needed. The QA Committee was to meet weekly, or more often if necessary, and discuss areas of concern that had been identified until sustained compliance with the corrective actions had been demonstrated. The QA Committee members were also to track and trend the audit findings to evaluate and implement needed improvements.</p> <p>Review of the AOC revealed the facility would monitor their continued compliance through audits conducted by the QAN to determine that</p>	F 490		

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F 490	<p>Continued From page 38</p> <p>policies and procedures implemented related to Advance Directives and the notification of a resident's physician, legal representative, or family member had been followed when a change in a resident's condition occurred. The QAN would complete the above evaluations monthly for three months or until sustained compliance has been determined. The AOC revealed Process Reviews would be completed on ten percent of the in-house census weekly to ensure continued compliance.</p> <p>The AOC revealed an external nurse consultant would review the audit results weekly and complete an additional audit of one chart weekly for three months, or until substantial compliance had been maintained by the facility. The AOC revealed the results of all facility reviews and/or audits would be reported to the QA Committee for review and recommendation of changes as needed.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Interview with the Administrator on 06/29/11, at 7:35 PM, and record review verified she had attended the Clinical Meetings and the QA Meeting. Per interview she would be attending the Clinical Meetings daily and the QA Meetings weekly and/or as needed, to ensure the above monitoring policies and procedures were being utilized. The Administrator stated the facility's external nurse consultant would complete weekly audits and would assist facility staff in the development of additional monitoring tools as they were needed.</p>	F 490			

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F 490	Continued From page 39 An interview with the facility's Medical Director on 06/29/11, at 4:00 PM, and record review verified he attended the QA Meeting. Per interview, he would be attending the weekly QA meeting and working closely with the facility staff to develop and/or implement the policies and procedures to ensure the facility maintained their compliance. Based on the above findings, it was determined the Immediate Jeopardy was removed on 06/29/11. Noncompliance continued with the scope and severity lowered to "D" based on the need for the facility to evaluate and implement systematic changes and quality assurance activities.	F 490		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	<u>F 520 (D) QAA Committee</u> <i>Residents Found to Have Been Affected</i> There were no specific residents identified in this deficiency. Counseling and education was provided to LPN #1; however, she is no longer employed at the center. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected. All nursing staff have been in serviced on the facility's policy and procedure for Advance Directives and identification of code status. A post test was completed to ensure staff's understanding and comprehension. <i>Systemic Changes</i> A comprehensive orientation agenda and checklist has been developed for new employees to ensure education is provided	

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F 520	<p>Continued From page 40</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, it was determined the facility failed to ensure the quality assessment and assurance committee was effective in identifying and correcting quality deficiencies related to orientation/training of new employees. There was no evidence the facility had an effective system to monitor the training/orientation for newly hired employees and to determine staff competency. Licensed Practical Nurse (LPN) #1 was hired by the facility on 05/17/11; however, the facility failed to provide the newly employed nurse with appropriate training related to facility policies/procedures regarding residents' Advance Directives and Code Status. (Refer to F281.)</p> <p>The findings include:</p> <p>A review of the facility's Quality Assurance Program (QAP) policy/procedures (no date) revealed the QAP was utilized by the facility to identify and address quality issues and to implement corrective action plans as necessary. The policy/procedures further noted the QAP Committee was responsible to monitor areas which negatively affect quality of care and services provided to the residents. The QAP policy further stated the committee would develop and implement plans of action to correct any identified quality deficiencies.</p>	F 520	<p>and comprehension is measured regarding the facility's policies and procedures including Advance Directives and identification of code status. All nursing staff will received mandatory bi-annual training on the facility's policy and procedure for Advance Directives and identification of code status as part of the routine in-service calendar. Post tests and competency skills checks are included as part of the orientation and inservice process.</p> <p>Monitoring</p> <p>Post tests have been developed to evaluate the effectiveness of orientation in inservices. The results of the post tests are evaluated by the QA Nurse and/or DON for trends and submitted to the QA Committee meeting for further review and recommendations as indicated. The QA Committee will continue to routinely review the content of the facility's new hire orientation and annual inservice calendar for additional recommendations and/or changes as needed. New hires will be re-evaluated within 3 months of hire date by additional post testing to ensure competency and retained comprehension of education received.</p>	8/15/2011	

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

PRINTED: 08/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2011
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314		
(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 520	<p>Continued From page 41</p> <p>A review of an orientation checklist revealed LPN #1 received general orientation on Business Office procedures, General/Human Resources, Environment, Social Services, Safety, and Infection Control when hired by the facility on 05/17/11. However, there was no evidence the facility provided LPN #1 with orientation/training regarding established facility policies/procedures for Advance Directives and Code Status. In addition, there was no evidence the facility had evaluated the effectiveness of the training to determine the competency of LPN #1.</p> <p>An interview conducted with the Quality Assurance Coordinator (QAC) on 07/27/11, at 1:35 PM, revealed the QAC performed random observation and monitoring of the medication administration pass, residents' shower and bowel movement records, food/fluid consumption records, interventions to prevent skin alteration, and performance of accuchecks to identify areas of concerns to be addressed by the QA Committee. The QAC stated she did not participate in evaluation of staff training and competency. The QAC further stated the facility did not have an audit tool to monitor for the effectiveness of new employee orientation/training or staff competency.</p> <p>The DON was interviewed on 07/27/11, at 3:35 PM, and stated the facility provided a random post test after a mandatory staff in-service to evaluate the effectiveness of the training, but this was not done routinely. The DON stated new staff orientation consisted of assignment with another employee for three shifts. The DON further validated there was no system to</p>	F 520			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2011
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P. O. BOX 250 BOONEVILLE, KY 41314		
(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 520	Continued From page 42 audit/monitor for the effectiveness of staff training/orientation and staff competency to determine if additional training was required for the new employee.	F 520			

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

PRINTED: 12/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/22/2011
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314		
(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	
K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on June 22, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70(a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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.