

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

PRINTED: 01/17/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/03/2014
NAME OF PROVIDER OR SUPPLIER MILLS HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066	

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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating #KY21129 was conducted on 01/02/14 through 01/03/14 and was substantiated with deficiencies cited.

F 157 483.10(b)(11) NOTIFY OF CHANGES SS=D (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

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Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.

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1. Resident #1 was placed on Hospice caseload on 1/15/2014 for management of terminal condition of End Stage CHF, Chronic Renal Failure and Failure to Thrive. Care plans for resident #1 were reviewed by the Interdisciplinary Team and the Hospice team with interventions revised as indicated on 1/15/2014.

Resident #3 returned to facility 12/21/2013 and placed on PO antibiotic 10 days. Care plans for resident #3 reviewed and revised by the Interdisciplinary Team as indicated on 1/10/2014.

2. All residents have the potential to be affected by untimely physician and representative notification when there is need to alter resident's treatment significantly.

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

David K. Lutz

TITLE

Administrator

(X6) DATE

1/23/14

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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This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to immediately inform the resident's physician of a need to alter treatment significantly for two of three sampled residents (Resident #1 and Resident #3).

The findings include:

Review of the Notification Requirements policy/procedure, revised 05/22/12, revealed the facility should notify the resident's attending physician and representative when there was a need to alter the resident's treatment significantly.

1. Record review revealed the facility admitted Resident #1 on 09/19/13 with diagnoses to include Stage III Chronic Kidney Disease, Hypertension, and Senile Dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/31/13, revealed the facility assessed the resident as severely cognitively impaired, always incontinent of bladder and frequently incontinent of bowel.

Review of the Discharge Summary, dated 12/12/13, revealed Resident #1 was admitted to the hospital on 12/09/13. The summary indicated the resident had been admitted with altered mental status and agitation, diagnosed having an Extended Spectrum Beta-Lactamase (ESBL) positive Escherichia coli (E-coli) urinary tract infection. The resident was discharged to the facility on 12/12/12, with the summary indicating the need for continued IV Merrem (antibiotic) 1000 milligrams (mg) every twelve hours at least

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The 24 Hour Change in Condition Reports for the month of December 2013 thru January 3, 2014 were reviewed by the Interdisciplinary Team to ensure physician timely notification for need to change treatment as indicated. The resident's physician was notified immediately for any identified concerns. Responsible party notification as indicated. Care plans of any identified residents were reviewed and revised as indicated by the Interdisciplinary Team by 1/21/14.
3. All nurses were re-educated by the staff development coordinator on regulation 483.10(b)(11) Notification of Changes with emphasis on notification of resident's physician immediately of a need to alter treatment significantly when identified, the use of the 24 hour change in condition report, and when to notify the Medical Director. Nurses must receive a call back from the MD to obtain new orders/clarification of orders before the end of their shift. If no response by the end of the shift the nurse will place on the 24 Hour Report for the on coming shift to continue attempts to notify the attending physician. If

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F 157	<p>Continued From page 2 until 12/20/13.</p> <p>Review of the Physician's Orders, dated 12/12/13, revealed an order for Meropenem one (1) gram vial infusion every twelve hours. Review of the nurse's notes, dated 12/13/13 at 9:30 AM, revealed a message was left at the physician's office to clarify the IV orders. On 12/13/13 at 10:30 AM, the physician's office called with an order to change medication to po (by mouth). The nurse's notes, dated 12/16/13, revealed another call was placed to the physician's office indicating the IV antibiotic had been discontinued without a new order in place. On 12/17/13 at 1:45 PM, the notes indicated a urinalysis with C&S was ordered at this time. Review of the urinalysis, dated 12/18/13, revealed a C&S was not indicated. The physician was faxed the results on 12/18/13 and 12/20/13.</p> <p>The facility could not provide documentation of any antibiotics received from 12/12/13 to 12/20/13.</p> <p>Review of the History & Physical, dated 12/20/13, revealed Resident #1 was admitted back to the hospital with a chief complaint of "weakness." The assessment and plan indicated the resident had an acute urinary tract infection with recent hospitalization for ESBL positive E-coli, sensitive to Meropenem. The IV antibiotics were started in the hospital.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 01/03/14 at 12:50 PM, revealed she remembered all the resident's medications were changed to po upon return from the hospital 12/12/13. She indicated the IV antibiotic did not come in po form, so the night shift nurse asked</p>	F 157	<p>no response within 24 Hours, the Medical Director will be notified by the Director of Nursing and/or Assistant Director of Nursing. The licensed nurse will continue to observe and assess the resident and document the findings during their attempts of notification with response. The Director of Nurses will be notified if there is no call back from the attending physician and/or the staff nurse is unable to resolve within 24 hours. The Director of Nurses will then work with the Administrator to obtain MD notification if indicated by notifying the Medical Director. The Administrator discussed with the medical staff the importance of timely response to the facility when a need to alter treatment is identified, the role of the medical director, and a copy of regulation 483.10(b)(11) Notification of Changes on 1/21/14. The Administrator and Director of Nurses re-educated the Medical Director on his responsibility as defined in the State Operations Manual on 1/17/2014.</p> <p>4. The Interdisciplinary Team will QI monitor the 24 Hour Condition Reports 5 times a week during the Abbreviated Quality Assessment and</p>	

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F 157	<p>Continued From page 3</p> <p>her to check on it 12/16/13. She revealed they were supposed to obtain clarification orders as soon as possible.</p> <p>Interview with the Unit Manager, on 01/03/14 at 1:55 PM, revealed she was told on 12/12/13 the resident came back to the facility without IV access. She instructed staff to call the physician, and an order was written to change the medication to po 12/13/13. Pharmacy called the facility, indicating the medication did not come in po form. She would have expected the nurse to inform the physician of the need for IV antibiotics, per the discharge summary. She revealed it was the nurse's responsibility to follow up and ensure orders were clarified timely by the physician. If a physician did not respond by the third day, the medical director should be notified. She revealed appropriate physician notification was not given, related to the resident having ESBL positive E-coli in the urine.</p> <p>Interview with the resident's Primary Physician, on 01/03/14 at 1:10 PM, revealed when the resident came back from the hospital 12/12/13, he/she did not have IV access. He indicated the facility called him to get an order to change the IV medication to po form. He revealed the facility did not make him aware the infection was sensitive only to the IV antibiotic. He would have expected staff to notify him of the lab work indicated by the discharge summary, as he would have ordered to restart the IV at that time. He revealed when the facility called his office 12/17/13, she was asymptomatic, so he ordered the urinalysis. When the resident was transferred to the hospital 12/20/13, he/she did have a urinary tract infection; however, the resident had multiple other chronic illnesses.</p>	F 157	<p>Assurance Meeting to ensure there is timely physician notification to discuss treatment changes. Any variances will be addressed immediately through re-education of staff member[s]. Findings will be brought to the Quality Assurance Performance Improvement meeting monthly for review and development of action plan to ensure the facility immediately informs the resident's physician when there is a need to alter treatment significantly.</p>	1/24/14

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Interview with the Director of Nursing (DON), on 01/03/14 at 2:20 PM, revealed staff should have notified the Medical Director of the need for an antibiotic order for Resident #1.

2. Record review revealed the facility admitted Resident #3 on 07/23/10 with diagnoses to include Neurogenic Bladder, Renal Failure, Hypertension, and Senile Dementia. Review of the quarterly MDA assessment, dated 11/07/13, revealed the facility assessed Resident #3's cognition as moderately impaired and the resident was frequently incontinent of bowel and bladder.

Review of the nurse's notes, dated 11/29/13 at 4:20 PM, revealed orders were received for a urinalysis with C&S, if indicated due to pain with urination. Review of the Urinalysis results, dated 11/29/13, revealed positive nitrates, moderate LK Esterase, 10-15 White Blood Cells, and 4+ bacteria. Results were faxed 11/30/13 per documentation. Review of the C&S results, dated 12/01/13, indicated the physician was notified. Documentation revealed a medication list was faxed to the physician 12/03/13.

The facility did not provide documentation of any new orders related to the urinalysis C&S from 11/29/13 to 12/15/13.

Review of the nurse's notes, dated 12/15/13 at 2:10 PM, revealed the resident was having confusion, complaints of pelvic pain, and diarrheal episodes. He/she was transferred and admitted to the hospital.

Interview with the Primary Physician for Resident

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F 157	<p>Continued From page 5</p> <p>#3, on 01/03/14 at 11:20 AM, revealed he received the initial urinalysis 11/30/13 and the culture report 12/01/13. He stated the facility was asked to send a current medication list with any symptoms the resident may be experiencing on 12/02/13. He indicated the facility told him the resident was having confusion with no fever. His notes indicated on 12/03/13 to add an intramuscular (IM) antibiotic for 5 days, called to the facility by his secretary. On 12/15/13, the resident was sent to the hospital for dehydration due to the protovirus; however, he/she was treated for a urinary tract infection during the stay. He revealed he would have preferred the resident receive the antibiotics when he ordered them, on 12/03/13.</p> <p>Interview with LPN #3, on 01/03/14 at 2:10 PM, revealed the physician was called several times about the resident's urinalysis C&S results. She revealed no calls or faxes were received by her for IM antibiotics on 12/03/13.</p> <p>Interview with LPN #2, on 01/03/14 at 12:50 PM, revealed she faxed the medication list to the physician on 12/03/13 per his request. She did not receive a call or fax from his office that day. She revealed the physician should have been called or faxed until orders were received.</p> <p>Interview with the DON, on 01/03/14 at 2:20 PM, revealed she expected staff to call by the end of their shift for orders and report in the morning if there was no response, so the Medical Director could be notified.</p>	F 157		