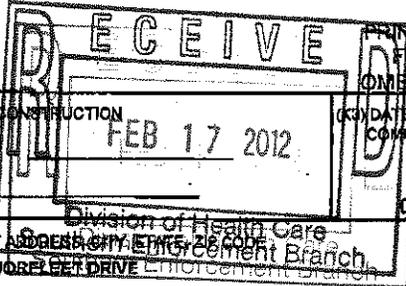


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/09/2012
FORM APPROVED
CMS NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2012
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING AND REHABILITATION CENTER	STREET ADDRESS 200 NORFOLK DRIVE SOMERSET, KY 42501
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY17732) was conducted on 01/25-26/12. The complaint was substantiated with deficient practice cited at "G" level, with an opportunity to correct.</p> <p>F 166 SS=G 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policies, it was determined the facility failed to ensure prompt efforts were taken to resolve grievances for one of three sampled residents. On 01/18/12, Resident #1's physician wrote an order to discontinue a medication the resident was taking. Registered Nurse (RN) #1 informed Resident #1's family member of the change in the resident's medications. The family member of Resident #1 informed RN #1 the resident could not be taken off the medication due to the resident's history of adverse effects as a result of not taking the medication. However, RN #1 failed to document the family member's concerns in accordance with facility policy and failed to ensure the resident's physician was informed of the family member's concern. Four days after the medication change, Resident #1 was hospitalized with a diagnosis of Severe Critical Hyperkalemia. (Refer to F309.)</p> <p>The findings include:</p>	F 000	<p>F 166</p> <ol style="list-style-type: none"> 1. Resident # 1 is no longer no longer resides in facility. 2. A one-time interview of all oriented residents was conducted by the Administrator, the Director of Nursing, Unit Managers, Social Service Director, Life Enrichment Director and Education and Training Director to identify any concerns related to care or medications. This will be completed by 2/17/12. Any issues will be resolved immediately. 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill Spurgeon TITLE: Adm. (X5) DATE: 2/17/12

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.

Received Time Feb. 17, 2012 2:37PM No. 5566

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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 209 NORFLEET DRIVE SOMERSET, KY 42501		
(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 16S	<p>Continued From page 1</p> <p>A review of the facility policy "Concern-Resident/Family" (dated 10/09) revealed any employee could receive a grievance/concern from a resident and/or family member of a resident. According to policy, the employee was to attempt to resolve the grievance/concern and complete a "Resident Concern Report," which was then given to the Administrator.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 12/21/11. Resident #1 had diagnoses to include Congestive Heart Failure, Chronic Airway Obstruction, and Coronary Artery Disease. A review of the medical record revealed upon admission the resident's medications included 40 meq (milliequivalents) of Potassium (electrolyte) twice a day and 40 milligrams (mg) of Lasix (diuretic) twice a day. Further review of the medical record revealed on 01/18/12, the resident's physician discontinued the Lasix and ordered Aldactone (a potassium-sparing diuretic) for the resident. Continued review of the medical record revealed Resident #1 was admitted to a hospital on 01/22/12, four days after the Lasix had been discontinued, with a diagnosis of Severe Critical Hyperkalemia (elevated potassium level).</p> <p>A review of the hospital record for Resident #1 revealed the resident's admitting physician consulted another physician and the consulting physician suspected the origin of Resident #1's severe hyperkalemia was the cessation of the Lasix, the addition of Aldactone, and the very high daily potassium supplement which, according to</p>	F 16S	<p>A one time interview of 30 resident family members was conducted by the Social Service Director, the Administrator, and the Life Enrichment Director, to identify any concerns with their family members' care or medication regime. This will be completed by 2/17/12. Any issues will be immediately addressed. Regional Director of Clinical Operations (RCDO) will review all grievances from 1/14/12 to 2/14/12 to identify any grievances that were not promptly resolved, and these issues will be immediately resolved. This will be completed by 2/17/12.</p> <p>A letter was sent out to all family members by the Administrator on 2/15/12 to identify any family member that may not be aware of the grievance policy, describing what a grievance is, where the form is located, how the</p>		

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F 166	Continued From page 2 the physician, was almost two times the daily potassium dietary intake. Interview with Resident #1's family member on 01/26/12, at 12:45 PM, revealed when the nurse informed the family member of the change in Resident #1's medication on 01/18/12, she explained to the nurse that Resident #1 could not be taken off the Lasix. The family member stated she was very "adamant" in telling the nurse that Resident #1 had a history of a Heart Attack when taken off the Lasix. Interview further revealed the daughter told RN #1, "I am telling you right now you can't take her off Lasix." The family member stated the nurse informed the family member that the physician had requested the medication change because Resident's #1's potassium was "low." Interview with RN #1 on 01/25/12, at 3:30 PM, revealed she received the order from Resident #1's physician on 01/18/12, to discontinue the resident's Lasix and to start the Aldactone for Resident #1. RN #1 stated she spoke with Resident #1's family member on the evening of 01/18/12, and informed the family member of the change in the resident's medications. Further interview revealed on 01/18/12, Resident #1's family member told the nurse Resident #1 could not be taken off of the Lasix because previously when the medication had been stopped Resident #1 experienced a "heart attack" and was told by a physician that the resident's heart attack was due to the Lasix being discontinued. Interview with RN #1 further revealed the family member asked RN #1 if the resident's physician was aware Resident #1 had Congestive Heart Failure and RN #1 explained to the family member that she	F 166	facility follows up, and the policy for prompt resolution. Administrator (ADM), Director(DON), and Unit Managers(UM) to call the facility nurses every shift, beginning 2/10/12 for 30 days to identify any concerns and assist staff with prompt resolution. 3. RDCO to re-educate the Adm., DON, and UMs regarding grievance policy and procedures, and prompt resolution on 2/15/12. The ADM, DON, and ETD to re-educate all staff by 2/18/12 regarding policy and procedures for grievances, to include: what is a grievance, who can fill out a grievance, prompt grievance resolution, and investigation. Adm, DON & UM's to call charge nurse each shift beginning 2/10/12 for 30 days then each shift three times a week for 60 days to ensure all	

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F 166	<p>Continued From page 3</p> <p>was sure the physician was aware. RN #1 stated she explained to the resident and the family member that facility staff would "watch her." In addition, RN #1 stated she thought the resident's family member was "okay" with the RN's response and stated she did not consider the family members statement regarding the physician's decision to discontinue the Lasix as a concern because the family member was not "Insistent" on the concern.</p> <p>Interview with Resident #1's physician on 01/25/12, at 8:00 PM, revealed he was not made aware by facility staff that Resident #1's daughter had voiced concerns related to the resident's Lasix being discontinued on 01/18/12. The physician stated even though he assumed care of Resident #1 on 12/21/11, he was not aware of the resident's medical history. According to the physician, if facility staff had informed him of the family member's concern, it would have made a difference in his decision to discontinue the Lasix.</p> <p>Interview with the Educator Training Director on 01/26/12, at 3:04 PM, revealed all staff was in-serviced upon employment on the facility's policy related to concerns/grievances from residents and or family members. The Director further stated that all staff also received in-service training related to what constituted a concern/grievance and the appropriate form to fill out when a resident or family member had a concern/grievance.</p> <p>Interview with RN #1 on 01/26/12, at 3:45 PM, revealed she did not recall if she was trained on what to do when a resident or family member voiced a concern or grievance, and was not</p>	F 166	<p>grievances are identified and followed up promptly per policy. The Social Services Director(SSD), the ADM, and the Life Enrichment Director(LED) to interview 6 resident family members and record on audit sheet each week beginning 2/20/12 for 60 days to ensure all grievances are noted, and followed up on promptly per policy. The ETD, DON, and UM's are to interview 6 residents beginning 2/20/12 and continue for 60 days, recording their results on an audit sheet to also ensure all grievances are noted and followed up on promptly per policy and procedure.</p>		

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F 166	Continued From page 4 aware where the concern/grievance forms were located. In addition, RN #1 acknowledged she had not completed a concern/grievance form as a result of the family member's concern related to the physician's decision to discontinue the resident's Lasix. Facility staff could not provide documentation that RN #1 had been trained on the concern/grievance process. Interview with the Administrator on 01/26/12, at 12:15 PM, revealed she was not made aware of the incident involving Resident #1 until 01/23/12, after the resident had been sent to the hospital. The Administrator stated staff should have listened to the family member's concern and should have notified the resident's physician of the family's concern since the physician was not aware of the resident's history. She further stated that RN #1 should have filled out a grievance/concern form after the family member voiced the concern.	F 166	4. The facility Quality Assurance Committee (consisting of at least, the ADM, DON, UM's, Education Training Director, Social Services Director and the Medical Director) will meet monthly beginning 2/2012 to review all audit findings and revise plan as needed based on the findings, until resolved. 5. Date of Compliance: 2/18/12.		
F 309 SS=G	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 a review of facility policies, it was determined the facility failed to provide the necessary care and services	F 309	F 309 1. Resident # 1 no longer resides in the facility.		

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F 309	<p>Continued From page 5</p> <p>to attain or maintain the highest practicable physical well-being for one of three sampled residents (Resident #1). Resident #1 was admitted to the facility 12/21/11, and had physician's orders for Potassium (electrolyte) and Lasix (a diuretic). On 01/18/12, the physician discontinued Resident #1's Lasix and ordered Aldactone (a diuretic). Resident #1's family member Informed Registered Nurse (RN) #1 on 01/18/12, that the resident had experienced a "heart attack" previously when Lasix had been discontinued and informed the nurse "you can't take her off." However, facility staff failed to assess and/or plan the resident's care after information was received about the resident's medical history. In addition, RN #1 failed to inform the resident's physician of the family member's concern and on 01/22/12, four days after the change in the resident's medications, Resident #1 was admitted to the Critical Care Unit of a hospital with diagnoses of Severe Critical Hyperkalemia and Congestive Heart Failure.</p> <p>The findings include:</p> <p>A review of the facility policy "Concern-Resident/Family" (dated 10/09) revealed any employee could receive a grievance/concern from a resident and/or family member of a resident. According to policy, the employee is to attempt to resolve the grievance/concern and complete a "Resident Concern Report," which is then given to the Administrator.</p> <p>Review of the medical record of Resident #1 revealed the facility admitted the resident on</p>	F 309	<p>2. A one-time interview of all oriented residents was conducted by the Administrator, the Director of Nursing, Unit Managers, Social Service Director, and Life Enrichment Director, and Education and Training Director to identify any concerns with medications and</p> <p>review medication list. This will be completed by 2/17/12. Any issues will be resolved immediately.</p>	

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F 309	<p>Continued From page 6</p> <p>12/21/11, with diagnoses that included Congestive Heart Failure, Chronic Airway Obstruction, and Coronary Artery Disease. Resident #1's medications included 40 milliequivalents (mEq) of Potassium (electrolyte) two times a day and 40 milligrams (mg) of Lasix (a diuretic) twice a day. A review of the resident's labs revealed on 01/11/12, a potassium level of 3.3 milliequivalents per liter (mEq/l) (normal 3.5-5.3 mEq/l). On 01/12/12, a physician's order was received to increase the potassium to 40 mEq four times a day. Continued review of the medical record revealed on 01/18/12, a potassium level of 3.0 mEq and a physician's order to discontinue the Lasix and begin Aldactone (a potassium-sparing diuretic) 25 mg twice a day.</p> <p>A review of Resident #1's Minimum Data Set (MDS) dated 12/28/11, revealed the facility assessed the resident's cognition to be intact, to require Oxygen Therapy, Diuretics, and Respiratory Therapy. Review of the resident's Comprehensive Care Plan (CCP) revealed a care plan for potential for alteration in circulation dated 01/03/12; the facility interventions included: medications/treatments as ordered, to update the physician/family as needed, labs as ordered, and for facility staff to monitor for signs and symptoms of cardiac distress. Continued review of the resident's CCP revealed a care plan for potential for/actual alteration in oxygen exchange dated 01/12/12; the facility interventions included to update the physician/family as needed, medications/treatments as ordered, and breathing treatments as ordered.</p> <p>An interview was conducted with Resident #1's</p>	F 309	<p>A one time interview of 30 resident family members was conducted by the Social Service Director, the Administrator, and the Life Enrichment Director, to identify any concerns with their family members' medication, and to review their residents current medication list/history. will be completed by 2/17/12. Any issues will be immediately addressed. RDCO to interview 5 residents and 5 families by 2/17/12 to identify and concerns with medication and review current medication lists/history.</p>		

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F 309	<p>Continued From page 7</p> <p>family member on 01/26/12, at 12:45 PM. According to the family member, a nurse had informed him/her on 01/18/12, that Resident #1's physician had discontinued the resident's Lasix. The family member stated he/she explained to the nurse that Resident #1 could not be taken off the Lasix. The family member stated he/she informed the nurse Resident #1 had a history of Heart Attack when the resident had been taken off Lasix in the past, and told the nurse, "I am telling you right now you can't take [him/her] off Lasix." The family member stated the nurse informed the family member that the physician had requested the medication change because Resident's #1's potassium was "low." In addition, interview with the family member revealed to his/her knowledge the nurse did not relay the information to the resident's physician.</p> <p>Interview with Registered Nurse (RN) #1 on 01/25/12, at 4:10 PM, revealed she worked on the evening of 01/18/12, when Resident #1's physician had been to the facility and written orders to discontinue the resident's Lasix and ordered Aldactone for the resident. RN #1 stated at approximately 6:00 PM, after the physician left the facility, she went to Resident #1's room to speak with the resident's family member and asked the family member if the physician had informed him/her of the change in the resident's medication. According to the nurse, the resident's family member informed the nurse the physician had not informed him/her of the medication change. Interview with RN #1 revealed she explained the physician had discontinued the resident's Lasix and had ordered Aldactone. RN #1 stated she explained to the resident's family member that both medications</p>	F 309	<p>3. RDCO to re-educate DON, UM's, and ETD on 2/15/12 regarding the policy and procedure on following up on medication concerns and ensuring that resident Plan of Care is updated based on history and medications.</p> <p>The DON/ETD is to re-educate all licensed nurses, and KMA's by 2/15/12, regarding follow up to family concerns-specifically medication concerns, and grievance policy and procedure. ETD, RCDO, ADM, and DON to re-educate all staff by 2/18/12 regarding policy and procedures for grievances that includes what is a grievance, who can fill them out, and prompt grievance resolution and investigation.</p>	

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F 309	<p>Continued From page 8</p> <p>were diuretics and that Aldactone was a potassium-sparing diuretic that the physician had probably ordered because Resident #1's potassium was low. Continued interview with RN #1 revealed Resident #1's family member informed her prior to the resident's admission to the facility that the resident's Lasix had been discontinued and as a result the resident experienced a Heart Attack. Based on interview with RN #1, the resident's family member stated the physician felt that the resident's Heart Attack was caused due to the discontinuance of the Lasix. A review of a History and Physical found on the resident's chart from a hospitalization prior to admittance to the facility, revealed the resident was hypokalemic (low potassium level) and had a elevated troponin level (a blood test used to check for damage to the heart). According to the documentation the primary physician at the hospital was unsure if the elevated troponin level was related to a heart attack or the recent reduction in the resident's Lasix. RN #1 also stated the resident's family member asked if the resident's physician was aware the resident had a history of Congestive Heart Failure and she explained to the family member that she was "sure" he was aware of Resident #1's diagnosis. Further interview with the nurse confirmed the family member had stated that the resident was "not" to be taken off the Lasix. However, RN #1 stated she had not notified the resident's physician of the family member's concerns related to the resident's history and medication change. She stated she did not feel the family member was "insistent" on the concern.</p> <p>Continued record review and interview with Licensed Practical Nurse (LPN) #3 on 01/25/12,</p>	F 309	<p>Adm, DON & UM's to call charge nurse each shift beginning 2/10/12 for 30 days then each shift three times a week for 60 days to ensure all grievances are identified and followed up promptly per policy. The Social Services Director(SSD), the ADM, and the Life Enrichment Director(LED) to interview 6 resident family members and record on audit sheet each week beginning 2/20/12 for 60 days to ensure all grievances are noted, and followed up on promptly per policy. The ETD, DON, and UM's are to interview 6 residents beginning 2/20/12 and continue for 60 days, recording their results on an audit sheet to also ensure all grievances are noted and followed up on promptly per policy and procedure. The DON and UM's will audit all charts, looking back 30 days (1/10/2012-2/10/2012) then all charts 5 X weekly for 30 days to ensure anv</p>		

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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORFLEET DRIVE SOMERSET, KY 42501		
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F 309	<p>Continued From page 9</p> <p>at 3:47 PM, revealed on 01/22/12, at 2:00 PM, Resident #1's family member informed LPN #3 the resident felt short of breath and requested a "breathing" treatment for the resident. LPN #3 noted the resident had labored breathing, was shaky, the resident's pulse oximetry (amount of oxygen in the blood) was 90 to 93 percent, and a "breathing" treatment was administered. After the administration of the breathing treatment, continued interview revealed the resident's family member was concerned the resident's assessed symptoms were the result of the change in the resident's medications. Documentation revealed LPN #2 notified the resident's physician and the physician requested for the resident to be transported to the hospital. Based on documentation in the medical record, four days after the Lasix was discontinued and the Aldactone was initiated, Resident #1 was transferred to the hospital and admitted to the Critical Care Unit of a hospital on 01/22/12, with a diagnosis of Severe Critical Hyperkalemia and Congestive Heart Failure.</p> <p>A review of Resident #1's hospital record revealed the resident's condition was "exceptionally guarded." Continued review of the resident's hospital medical record revealed the resident's consulting physician documented "I certainly suspect" the origin of Resident #1's severe critical hyperkalemia was the cessation of the Lasix, the addition of Aldactone, and the very high daily potassium supplement which, according to the physician, was almost two times the daily potassium dietary intake.</p> <p>Interview conducted on 01/25/12, at 6:00 PM, with Resident #1's physician at the facility</p>	F 309	<p>medication changes or any change of condition was reported to the family and physician timely and any family concern regarding medication changes were communicated to the physician.</p> <p>4. The facility Quality Assurance Committee (consisting of at least, the ADM, DON, UM's, Life Enrichment Director, Social Services Director, Education Training Director and the Medical Director) will meet monthly to review all audit findings and revise plan as needed based on the findings, until resolved.</p> <p>5. Date of Compliance: 2/18/12</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2012
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORFLEET DRIVE SOMERSET, KY 42501		
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F 309	<p>Continued From page 10</p> <p>revealed he discontinued the resident's Lasix and prescribed the Aldactone in an effort to get the resident's potassium level within a normal range. He further stated he had previously increased the potassium medication for Resident #1; however, the potassium level had still dropped from 3.3 to 3.0 and he "thought" it was "okay" at the time to discontinue the Lasix. The physician stated he was not aware the resident's family had expressed a concern related to his decision to discontinue the Lasix and that if facility staff had informed him of the family member's concern, it would have made a difference in his decision to discontinue the Lasix. Interview with the physician further revealed he had assumed medical care of the resident when the resident was initially admitted to the long term care facility and was not aware of the resident's past medical history.</p> <p>Interview with the Administrator on 01/26/12, at 12:15 PM, revealed she was not aware of the incident involving Resident #1 until 01/23/12, the day after the resident was transferred to the hospital. The Administrator stated staff should consider residents' and/or family members' concerns related to care and acknowledged facility staff should have made the physician of Resident #1 aware of the resident's family member's concerns related to his/her medical care.</p>	F 309			