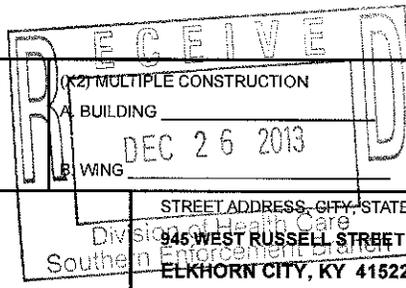


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185230</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/04/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>945 WEST RUSSELL STREET ELKHORN CITY, KY 41522</b>
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F 000	INITIAL COMMENTS  An abbreviated standard survey (KY21031) was initiated on 12/02/13 and concluded on 12/04/13. The complaint was substantiated with deficient practice identified at "D" level.	F 000	<b>F412</b> 1.) Resident #1 was seen by an oral surgeon on December 16, 2013, and has a subsequent appointment with the surgeon on February 03, 2014 pending results of diagnostic testing to occur on January 27, 2013 (appointments are not made at the PMC Diagnostic Center).	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS  The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.  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 obtain routine dental services to meet the needs of residents and to assist residents in making appointments for one of three sampled residents. A dentist assessed Resident #1 on 09/13/13 and recommended to the resident's family member for the resident to be evaluated by an oral surgeon because the dentist could not evaluate the resident due to the resident's combative behavior. However, the facility failed to make an appointment for Resident #1 to be evaluated by the oral surgeon until 11/27/13, two months and fourteen days after the dentist had made the recommendation.	F 412	2.) A review of Change in Condition logs which captures any changes from the resident's baseline, were completed by the Director of Nursing/Assistant Director of Nursing on December 05, 2013, for the previous 30 days, to ensure that an appointment was made for resident with symptoms that required dental services.  A review of residents with outside appointments for the last 30 days was completed on by the Director of Nursing/Assisted Director of Nursing on December 05, 2013 to ensure recommendations were obtained and implemented. The Health Information Manager to request any consultation reports not in the clinical record.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judith Bonham</i>	TITLE <i>EXECUTIVE Director</i>	(X6) DATE <i>12/23/13</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 412	<p>Continued From page 1</p> <p>The findings include:</p> <p>A review of the facility's Dental Services Policy (undated) revealed residents were provided with routine and emergency dental care when needed.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 09/26/12 with diagnoses that included Altered Mental Status, Dementia with Behavioral Disturbance, Anxiety, and Personality Disorder. Continued review of the medical record revealed Resident #1 had exhibited signs and symptoms of oral pain on 09/03/13, received pain medications, and the facility scheduled a dental appointment for the resident for 09/13/13. Based on the record review, Resident #1 was seen by the dentist on 09/13/13 and an antibiotic was prescribed for the resident for an infected tooth. There was no additional evidence of any other dental follow-up or appointments in the resident's medical record.</p> <p>Observation during a skin assessment conducted by facility staff for Resident #1 on 12/03/13 at 10:00 AM revealed the resident had three natural teeth with visible dental caries and discoloration on all three teeth.</p> <p>An interview conducted on 12/03/13 at 3:15 PM, with the resident's family member revealed he/she had transported Resident #1 to the dental appointment on 09/13/13 and reported the dentist was unable to examine the resident due to the resident's behaviors. According to the family member, the dentist suspected Resident #1 had an infected tooth and prescribed an antibiotic for the resident. The family member also stated the dentist recommended for Resident #1 to see an</p>	F 412	<p>3.) In-service was provided to the Health Information Manager and Nurse Managers by the Assistant Director of Nursing on December 5, 2013 regarding obtaining recommendations from outside providers, including dental services, and ensuring follow up of recommendations and securing appointments as recommended. The Unit Managers will be responsible for ensuring the appointments are made. Once the Consultant reports have been received they will then be placed in the resident's clinical record.</p> <p>Change in Condition logs will be audited by the Director of Nursing/ADON or Nursing Supervisor, to ensure that an appointment was made for any resident with symptoms that required dental services.</p> <p>Appointments will be audited daily, by the Unit Managers or Nursing Supervisors, and documented on the Transfer Log, to ensure receipt of Consultation reports and any further instructions and/or additional appointments are followed. The Consultation</p>		

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F 412	<p>Continued From page 2</p> <p>oral surgeon for an evaluation. Further interview with the family member revealed the resident had not seen an oral surgeon, and after the family member complained to the Director of Nursing (DON) that an appointment had not been scheduled the facility made the resident an appointment with the oral surgeon for 11/27/13.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #2 on 12/04/13 at 8:56 AM, revealed Resident #1's family member had transported the resident to the dentist on 09/13/13 and the LPN had provided care for Resident #1 when the resident returned to the facility. LPN #2 stated the resident's family member reported the dentist had recommended for the resident to be evaluated by an oral surgeon due to the resident's combative behaviors but the resident's family member had wanted "to wait." Further interview with LPN #2 revealed there was no written consultation provided from the dentist office with the reported recommendations.</p> <p>An interview conducted with LPN #1 on 12/03/13 at 11:17 AM, revealed the LPN had contacted an oral surgeon on 11/14/13 and had faxed resident information to the oral surgeon's office. However, the office staff at the oral surgeon's office stated the oral surgeon rarely saw Medicaid patients and did not schedule an appointment for the resident.</p> <p>An interview conducted on 12/03/13 at 3:00 PM with the dentist revealed he had assessed Resident #1 on 09/13/13, but the resident was combative and the dentist could not perform a complete examination of the resident's teeth. According to the dentist, he had discussed an antibiotic with the resident's primary care physician and recommended the resident see an</p>	F 412	<p>report will then be placed in the clinical record.</p> <p>The Transfer Logs, to include receipt and implementation of consultation reports, will be audited by the Director of Nursing/Assistant Director of Nursing Monday through Friday.</p> <p>4.) Results of Change in Condition log audits and Transfer Logs audit will be reviewed in the Performance Improvement Meeting which is attended by the Executive Director, Director of Nursing, Assistant Director of Nursing, Nursing Unit Managers, Health Information Manager, Admissions Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Social Services Director, Medical Staff Director, and support services managers if needed for the next 3 months.</p> <p>5.) December 13, 2013</p>		

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F 412	Continued From page 3 oral surgeon. Further interview with the dentist revealed he did not routinely provide written information to the nursing facility but would give his recommendations to whoever came with the resident.  An interview conducted with the Director of Nursing (DON) on 12/03/13 at 4:15 PM, revealed Resident #1's family member informed her on 11/18/13 of the recommendation made by the dentist on 09/13/13 for Resident #1 to be evaluated by an oral surgeon and that the resident had not been assessed by an oral surgeon. According to the Director of Nursing, she made multiple attempts to contact an oral surgeon, but the oral surgeon had been on vacation and she had not been successful. Further interview with the DON revealed she contacted another oral surgeon on 11/27/13 and scheduled an appointment for the resident to be assessed by the surgeon on 12/03/13; however, according to the DON, the resident's family declined the appointment due to the increased distance the resident would be required to travel. The DON provided a written log of attempts to contact the oral surgeon. A review of the written log revealed an attempt had been made to contact the oral surgeon on 11/27/13.	F 412			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	F514 1.) Resident #1 was seen by an oral surgeon on December 16, 2013, and has a subsequent appointment with the surgeon on February 03, 2014 pending results of diagnostic testing to occur on January 27, 2013 (appointments are not made at the PMC Diagnostic Center).  2.) A review of Change in Condition logs which captures any changes from the resident's baseline, were completed by the Director of Nursing/Assistant Director of Nursing on December 05, 2013, for the previous 30 days, to ensure that an appointment was made for resident with symptoms that required dental services.		

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F 514	<p>Continued From page 4</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policy it was determined the facility failed to maintain clinical records on each resident that were complete, accurately documented, readily accessible, and systematically organized in accordance with accepted professional standards and practices for one of three sampled residents. Interviews revealed a dentist assessed Resident #1 on 09/13/13, made a recommendation to the resident's family member for the resident to be evaluated by an oral surgeon, and, based on interviews, upon the resident's return to the facility the family member informed nursing staff at the facility of the dentist's recommendation. However, a review of Resident #1's medical record revealed no documentation of the dentist's recommendation or that the facility had made arrangements for Resident #1 to be evaluated by the oral surgeon until 11/27/13, two months and fourteen days after the dentist had made the recommendation.</p> <p>The findings include:</p> <p>A review of the facility policy titled Record Management with a revision date of 01/22/08, revealed no evidence of what was required to be documented in the resident's medical record</p>	F 514	<p>A review of residents with outside appointments for the last 30 days was completed on by the Director of Nursing/Assistant Director of Nursing on December 05, 2013 to ensure recommendations were obtained and implemented. The Health Information Manager to request any consultation reports not in the clinical record.</p> <p>3.) In-service was provided to the Health Information Manager and Nurse Managers by the Assistant Director of Nursing on December 5, 2013 regarding obtaining recommendations from outside providers, including dental services, and ensuring follow up of recommendations and securing appointments as recommended. The Unit Managers will be responsible for ensuring the appointments are made. Once the Consultant reports have been received they will then be placed in the resident's clinical record.</p> <p>Change in Condition logs will be audited by the Director of Nursing/ADON or Nursing Supervisor, to ensure that an appointment was made for</p>		

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F 514	<p>Continued From page 5</p> <p>regarding dental visits, however, according to the policy, medical information must be filed in the resident's record at least weekly so staff may have access to the results.</p> <p>An interview conducted with Resident #1's family member on 12/03/13 at 3:15 PM, revealed the dentist could not examine the resident on 09/13/13 due to the resident's combative behavior. The family member stated the dentist had recommended an antibiotic be prescribed for the resident and had informed the family member the resident also needed to be assessed by an oral surgeon. According to the family member, he/she had informed staff at the facility of the dentist's recommendation upon return from the dental appointment on 09/13/13. However, the family member stated the resident was having tooth pain and the facility had not scheduled an appointment with the surgeon.</p> <p>A record review conducted for Resident #1 revealed the resident was transported to the dentist's office and returned to the facility by a family member on 09/13/13. According to documentation in the nurse's notes dated 09/13/13, the family member informed the nurse that the dentist reported the resident had an infected tooth and had prescribed an antibiotic. However, there was no evidence in the resident's record that the dentist wanted the resident to be evaluated by an oral surgeon or any appointments scheduled for Resident #1 to see an oral surgeon.</p> <p>An interview conducted on 12/03/13 at 3:00 PM with the dentist confirmed he had attempted to examine Resident #1 on 09/13/13. According to the dentist, he could not examine Resident #1</p>	F 514	<p>any resident with symptoms that required dental services.</p> <p>Appointments will be audited daily, by the Unit Managers or Nursing Supervisors, and documented on the Transfer Log, to ensure receipt of Consultation reports and any further instructions and/or additional appointments are followed. The Consultation report will then be placed in the clinical record.</p> <p>The Transfer Logs, to include receipt and implementation of consultation reports, will be audited by the Director of Nursing/Assistant Director of Nursing Monday through Friday.</p> <p>4.) Results of Change in Condition log audits and Transfer Logs audit will be reviewed in the Performance Improvement Meeting which is attended by the Executive Director, Director of Nursing, Assistant Director of Nursing, Nursing Unit Managers, Health Information Manager, Admissions Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Social Services Director, Medical Staff Director,</p>		

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F 514	<p>Continued From page 6</p> <p>due to the resident's behaviors and had informed the person that accompanied the resident that the resident needed an antibiotic due to a possibly infected tooth and also needed to be evaluated by an oral surgeon. Further interview with the dentist revealed he had not provided written documentation of his recommendations to the facility.</p> <p>An interview on 12/04/13 at 8:56 AM, with Licensed Practical Nurse (LPN) #2 revealed the LPN had provided care for Resident #1 on 09/13/13. According to the LPN, when the resident returned from the dentist, the resident's family member informed the nurse that the dentist recommended Resident #1 to see an oral surgeon for further evaluation. However, LPN #2 stated the resident's family member had not provided a written consultation from the dentist office with the dentist's recommendations. LPN #2 stated she had not documented the conversation with Resident #1's family member in the medical record on 09/13/13, and had not contacted the dentist's office to confirm the information reported by the resident's family member.</p> <p>Interview with the Director of Nursing (DON) conducted on 12/03/13 at 4:15 PM, revealed the DON became aware Resident #1 had not seen an oral surgeon on 11/18/13 when she was informed by Resident #1's family. According to the Director of Nursing, she had made multiple attempts to reach the oral surgeon and was not successful due to the oral surgeon being on vacation. Further interview revealed the DON contacted another oral surgeon on 11/27/13 and scheduled an appointment for Resident #1 for 12/03/13. However, the DON stated the</p>	F 514	<p>and support services managers if needed for the next 3 months.</p> <p>5.) December 13, 2013</p>		

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F 514	Continued From page 7 resident's family declined the appointment due to the increased distance the resident would have to travel. According to the DON, she had made notes regarding the appointment with the oral surgeon and of the communication she had with Resident #1's family member but had not documented the communication in the resident's medical record.	F 514			