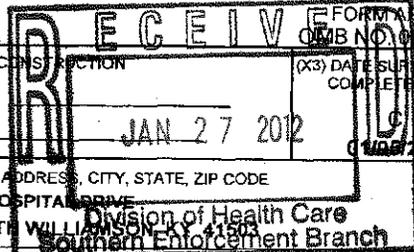


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED JAN 27 2012
NAME OF PROVIDER OR SUPPLIER  WILLIAMSON ARH			STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILMINGTON, KY 41503 Division of Health Care Southern Enforcement Branch	
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 157 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated standard survey (KY17550) was initiated on 01/04/12 and concluded on 01/05/12. The complaint was substantiated. Deficient practice was identified at "D" level.</p> <p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></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> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p><b>PLAN OF CORRECTION</b></p> <p>F157</p> <p><b>I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident #1 regarding complaint was discharged from facility prior to survey or complaint. Interview was conducted prior to survey with resident and daughter.</p> <p><b>II. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</b> All residents have the potential to have been affected by the same practice. There were 29 residents in the facility on 1/9/2012. In-service was provided to staff (See Attachment #1) on 1/9/2012 by DON/NHA</p>	
				1/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sergio J. Hasserman, R, DON, NHA* TITLE: DON/NHA (X6) DATE: 1/27/2012

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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(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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policies, the facility failed to ensure the legal representative/interested family member for one of three sampled residents (Resident #1) was notified when the resident experienced a significant change in condition. Resident #1 became confused and incontinent on 12/12/11 and 12/13/11, however, a review of documentation revealed no evidence the resident's legal representative/interested family member had been notified when the change in the resident's condition occurred.</p> <p>The findings include:</p> <p>A review of the Resident Rights Policy (no date listed) revealed the resident and/or his/her representative had the right to be fully informed of the resident's medical condition.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 10/21/11, with diagnoses of Total Knee Replacement, Seizure Disorder, Hypertension, Chronic Obstructive Pulmonary Disease, Ileostomy, and Cardiovascular Disease. A review of the Minimum Data Set (MDS) admission assessment revealed Resident #1's speech was clear, and the resident could be understood and could usually understand. The facility conducted a Brief Interview of Mental Status (BIMS) assessment of the resident and based on the assessment the resident had moderate mental impairment. According to the MDS, Resident #1</p>	F 157	<p>regarding the implementation of a new flow sheet for documentation of notification of changes in condition, need to alter treatment significantly, and notification of change in conditions or status of resident conveyed to resident and / or representative . The flow sheet was implemented on 1/9/2012 for all 29 current residents and will be utilized with each new admission to the facility (See Attachment #2).</p> <p><b>III. Address what measures will put into place or systemic changes made to ensure that the deficient practice will not recur:</b></p> <p>A education flow sheet was developed (See Attachment #2) to provide a tool to staff for documentation of education and notification</p>	

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F 157	<p>Continued From page 2</p> <p>required cues to answer short-term memory questions, but had no problems remembering the distant past. In addition, based on the facility's assessment, the resident had no delirium or identified behaviors.</p> <p>A review of the physician's orders for Resident #1 revealed the resident's medications had included Dilantin (anticonvulsant) 100 milligrams twice a day; however, on 10/31/11, the physician requested the Dilantin to be increased to 200 milligrams twice daily. In addition, based on a review of the physician's orders, on 11/04/11, the resident's Dilantin dose was increased to 200 milligrams three times a day.</p> <p>A review of the nurse's notes dated 10/31/11 and 11/04/11 revealed no evidence Resident #1's daughter was notified of the changes in the resident's medication therapy.</p> <p>A review of dietary notes dated 11/11/11 revealed Resident #1 experienced a 7.3 pound weight loss since 10/21/11. The physician and the Registered Dietitian were notified and interventions were implemented, however, there was no evidence the resident's daughter was notified of the resident's weight loss.</p> <p>In addition, a review of the nurse's/nurse aide's notes dated 12/03/11 revealed Resident #1 was alert/oriented, talkative, and cooperative. The notes further revealed the resident required one staff person for assistance to the bathroom and could complete his/her ileostomy care without assistance. However, based on documentation, on 12/12/11, Resident #1 was confused and incontinent. Although the resident's family</p>	F 157	<p>on changes in meds, treatments and changes in condition to identify and document who was notified or educated. This flow sheet will be kept with the residents Medication Record each month and will be implemented for each new admission and was implemented for all 29 residents in the facility on 1/9/2012 with accompanying in-service (See Attachment #1).</p> <p><b>IV. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:</b></p> <p>A PI monitor has been implemented and the DON/NHA will monitor (See attachment #3). Medication book will be checked at the beginning of each month and with each admission to ensure the use of the tool with each resident</p>	

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F 157	<p>Continued From page 3</p> <p>member contacted the facility to inquire about the resident's condition at that time, the facility only informed the family member the resident's physician had requested a consultation for the resident with a neurologist. There was no evidence the resident's family member had been notified of the change in Resident #1's mental status or that the resident had become incontinent.</p> <p>Continued review of documentation revealed on 12/13/11, Resident #1 continued to be confused/incontinent and the resident's family member had again called the facility to ask about the resident's status. According to documentation facility staff informed the resident's family member the resident had experienced nausea and vomiting; however, it could not be determined by a review of documentation that the resident's family member had been informed of the resident's mental status or incontinence.</p> <p>A review of the December dietary notes dated 12/16/11 revealed the resident had continued to lose weight and had lost an additional 6.9 pounds from 11/11/11 to 12/16/11. Based on documentation, the physician and dietitian were notified of the resident's weight loss, however, there was no evidence the resident's family member had been notified of the resident's additional weight loss.</p> <p>An interview conducted with Resident #1's family member on 01/03/12, at 4:05 PM, revealed the family member "sometimes" contacted the facility two times a day to ask about the resident's status. The family member further stated he/she</p>	F 157	Weekly random checks will be performed to ensure the utilization of the tool (See Attachment #4). The data will then be compiled and reported to the quarterly SNF PI committee.	

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F 157	Continued From page 4 had not been informed of the increase in the dosage of the resident's medication, Dilantin, and had not been informed of the change in the resident's mental status, the resident's weight loss, or of the resident's incontinence.  An interview conducted with Licensed Practical Nurse (LPN) #1 on 01/04/12, at 6:20 PM, revealed the nurse would call the physician for weight changes, mental status changes, or any significant changes. LPN #1 further stated she might wait until the family arrived to visit the resident to inform them of any changes that have occurred.	F 157			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure services provided by and/or arranged by the facility met professional standards for one of three sampled residents at the facility (Resident #1). Based on documentation, Resident #1 had physician's orders for a Dilantin (anticonvulsant) level to be drawn on 10/22/11 and then monthly. However, based on documentation, it could not be determined the facility had obtained the requested medication level on a monthly basis as requested in December 2011. Documentation revealed the resident's Dilantin level had not been obtained in December 2011 until 12/14/11, fourteen days past the date it was to be collected	F 281	PLAN OF CORRECTION  F281  <b>I. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</b>  Resident #1 from complaint was discharged from facility prior to survey or complaint. Interview was conducted prior to survey with resident and daughter.	1/9/12	

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F 281	<p>Continued From page 5 as requested by the physician.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing/Acting Administrator on 01/05/12, at 5:00 PM, revealed the facility did not have a policy related to routine laboratory testing; however, according to the DON the facility usually obtained routine monthly laboratory tests near the first of the month.</p> <p>A review of the medical record for Resident #1 revealed the resident was admitted to the facility on 10/21/11, with diagnoses that included Seizure Disorder. A review of the physician's admission orders dated 10/21/11 revealed the facility was to obtain a Dilantin level on 10/22/11 and then monthly for Resident #1. On 10/30/11, the physician requested an additional Dilantin level to be obtained. As a result of the findings of the Dilantin level obtained on 10/30/11, Resident #1's physician increased the resident's Dilantin dosage and requested another Dilantin level to be obtained on 11/04/11. The resident's Dilantin dosage was again increased and at that time there were no additional physician's orders related to the resident's Dilantin levels other than to obtain the Dilantin level on a monthly basis. There was no evidence the resident's Dilantin level was obtained until 12/13/11, when the neurologist who had been consulted on 12/12/11, requested the Dilantin level be obtained.</p> <p>An interview with the facility's Director of Nursing (DON) on 01/05/12, at 5:00 PM, revealed on 10/21/11, the resident's physician had ordered monthly monitoring of Resident #1's Dilantin level. The DON stated the resident's levels obtained on</p>	F 281	<p><b>II. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents have the potential to have been affected by the same practice. There were 29 residents in the facility on 1/9/2012. For all 29 residents that were present on 1/9/2012 a new monthly lab form with a list of orders for each resident was implemented for each. This includes a listing of monthly lab orders (See Attachment #5) by resident. This form was implemented for the current 29 residents and will be utilized for all new admissions to the facility. Also at that time a review of residents was completed to ensure all monthly labs were done.</p>	

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F 281	Continued From page 6 11/04/11, revealed the Resident's Dilantin levels were sub-therapeutic and the medication dosage was increased. The DON further stated a Dilantin level was obtained in accordance with physician's orders dated on 12/13/11 and, according to the DON, facility staff had failed to obtain the Dilantin level on 12/04/11, in accordance with the physician request for the Dilantin levels to be obtained on a monthly basis. According to the DON, the ward clerk for the unit was inexperienced and had failed to complete the request for the monthly Dilantin level. However, according to the DON, she was overall responsible to ensure orders were completed and had failed to do so.	F 281	The review found that for any resident admitted on or before 1/1/12 that all monthly orders were performed for 1/2012 for all current 29 admitted residents (See Attachment #6).  <b>III. Address what measures will put into place or systemic changes made to ensure that the deficient practice will not recur:</b>  A new form was implemented (See Attachment #5) with a listing of monthly labs as ordered by the physician for each resident. Monthly lab orders will be listed and kept by the unit clerk at the nurses' station for reference. As the orders are entered each month they will be check off in the box listed for that month and then double checked by the licensed nurse to ensure the labs were done.		

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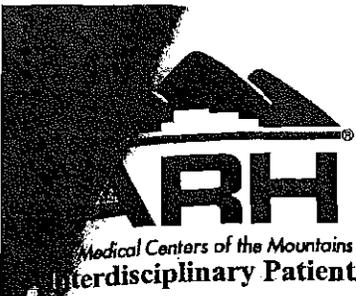
1/9/2012

Documentation and Notification of change in condition/treatment/therapy:

See attachment:

Changes in medications and education related to such changes are to be entered on interdisciplinary sheet and a new sheet is to be placed in the residents MARS each month. Resident's that do not wish to have representative's notified must also be documented (see attached copy of form). Notification is to be made to resident and their POA / Representative and documented. Make sure that you are making a note on any other changes as you speak to the resident or to their representatives. Charting is to be done in relation to what is currently happening or is of concern r/t the resident and specific to residents condition and all notifications of changes in condition.

*Resident Label*  
*- Modified POA / and if resident not notified - Resident declines to notify*



**Interdisciplinary Patient/Family Education Record**

Date	Time	Medication/Treat	Teaching Method	Evaluation of Learning	Individual Trained	Dept Code	Initials	POA Notified	Decline POA Notified
11/10/12	1200	Dilantin 200mg	E	VU	1	N			✓
11/12/12	1325	Occup. Ther DC Physical Ther	E	VU	1/6	N		✓	

Initials	Name/Title	Initials	Name/Title

**Teaching Method**

- E - Explanation
- P - Printed Materials
- D - Demonstration
- A - Audio/Video

**Evaluation of Learning**

- VU - Verbalize Understanding
- DR - Demonstration Returned
- NR - Needs Reinforcement

**Individual Trained**

- 1 - Patient
- 2 - Spouse
- 3 - Caregiver
- 4 - Parent; Mother or Father
- 5 - Significant Other
- 6 - Other \_\_\_\_\_

**Department Code**

- A - Anesthesia
- D - Dietary
- HC - Home Care
- IC - Infection Control
- N - Nursing
- NP - Nurse Practitioner
- MD/DO - Physician
- OR - Surgical Services
- OT - Occupational Therapy
- SS - Social Services
- ST - Speech Therapy
- PT - Physical Therapy

## QUALITY IMPROVEMENTS

HOSPITAL: Williamson      DEPARTMENT: SNF      REPORT DATE: 4/2012  
MONITORING PERIOD: 1/12-3/12      SAMPLE: all  
DATA SOURCES: Use of education flow sheet      CATEGORY:  
METHODODOLOGY: Weekly Check      PREPARED BY: RN, BSN

**ASPECT OF CARE: Resident Rights**

---

**1. INDICATOR/THRESHOLD FOR EVALUATION:**

Staff will implement a education flow sheet with each new admission to the facility 100% of the time.

**FINDINGS/EVALUATION:**

**CONCLUSIONS:**

**RECOMMENDATIONS/ACTIONS:**

**EFFECT OF PREVIOUS ACTIONS:**

**FOLLOW-UP DATE:**

---

**2. INDICATOR/THRESHOLD FOR EVALUATION:**

**FINDINGS/EVALUATION:**

**CONCLUSIONS:**

**RECOMMENDATIONS/ACTIONS:**

**EFFECT OF PREVIOUS ACTIONS:**

**FOLLOW-UP DATE:**



## QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: 4/2012  
MONITORING PERIOD: 1/12-3/12 SAMPLE: all  
DATA SOURCES: Use of education flow sheet CATEGORY:  
METHODODOLOGY: Weekly Check PREPARED BY: ; RN, BSN

**ASPECT OF CARE: Resident Rights**

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**1. INDICATOR/THRESHOLD FOR EVALUATION:**

Staff will implement a education flow sheet with each new admission to the facility 100% of the time.

**FINDINGS/EVALUATION:**

**CONCLUSIONS:**

**RECOMMENDATIONS/ACTIONS:**

**EFFECT OF PREVIOUS ACTIONS:**

**FOLLOW-UP DATE:**

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**2. INDICATOR/THRESHOLD FOR EVALUATION:**

**FINDINGS/EVALUATION:**

**CONCLUSIONS:**

**RECOMMENDATIONS/ACTIONS:**

**EFFECT OF PREVIOUS ACTIONS:**

**FOLLOW-UP DATE:**



# Attachment # 5

Resident: \_\_\_\_\_

Room: \_\_\_\_\_ Physician: \_\_\_\_\_

DX: Cellulitis

Year: 2012

Resident Initials  
  
*Example*

ordered labs by physician

Lab	Frequency
CBC	monthly
CMP	monthly
TSH	q 6mo

Flow for labs not monthly but q 6 or q 3mo  
check off that are ordered by clerk or licensed nurse  
check initials of follow check by RN/DON

Jan	Feb	March	April	May	June
TSH <i>SW</i>					

July	Aug	Sept	Oct	Nov	Dec
TSH					

## QUALITY IMPROVEMENTS

HOSPITAL: Williamson DEPARTMENT: SNF REPORT DATE: 4/2012  
MONITORING PERIOD: 1/12-3/12 SAMPLE: all  
DATA SOURCES: Monthly lab order flow sheet CATEGORY:  
METHODODOLOGY: Admit and monthly checks PREPARED BY: RN, BSN

**ASPECT OF CARE: Professional Services**

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**1. INDICATOR/THRESHOLD FOR EVALUATION:**

Staff will utilize the monthly lab flow sheet with each new admit and all current residents and check of when done with a second check for completion by registered nurse or DON monthly to ensure labs are done as ordered with a goal of 100% compliance.

**FINDINGS/EVALUATION:**

**CONCLUSIONS:**

**RECOMMENDATIONS/ACTIONS:**

**EFFECT OF PREVIOUS ACTIONS:**

**FOLLOW-UP DATE:**

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**2. INDICATOR/THRESHOLD FOR EVALUATION:**

**FINDINGS/EVALUATION:**

**CONCLUSIONS:**

**RECOMMENDATIONS/ACTIONS:**

**EFFECT OF PREVIOUS ACTIONS:**

