STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185120	A. BUILDING B. WING	C 10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

(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 000	INITIAL COMMENTS An abbreviated survey (KY #19187 and KY #19114) was conducted on 10/09/12 through 10/12/12 to determine the facility's compliance with Federal requirements. The facility was found not to meet Federal requirements with deficiencies cited. KY #19187 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 10/11/12 and determined to exist on 09/29/12 at 42 CFR 483.20 Resident Assessment, F-281 and F-282, 42 CFR 483.75 Administration, F-490. KY #19114 was unsubstantiated with no deficient practice identified. Based on interview, record review, and review of the facility's policy/procedures, it was determined the facility failed to follow physician's orders for providing cardiopulmonary resuscitation (CPR) in the event of the residents change in condition, which included cessation of breathing and heart beat for one resident (#1), in the selected sample of five residents. The facility failed to have an effective system in place and to ensure staff was trained and knowledgeable to accurately identify residents' code status in the event of cardiac and respiratory arrest and initiate as appropriate. On 04/01/09, upon admission the facility detailed Resident #1's code status as CPR (full code) in the event cessation of breathing and heart beat. The physician's order, dated 09/01-30/12, detailing Resident #1 had full code status. On 09/29/12 at 8:00 AM, Registered Nurse (RN) #1 assessed and determined that Resident #1 began to have seizures then ceased breathing and having a heart beat. The facility staff failed to accurately identify that Resident #1 was to have CPR initiated, per the physician's order and care	F 000	Past noncompliance: no plan of correction required.	

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.

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F 000	Continued From page 1 plan, when LPN #1 reported to RN #1 that the resident was Do Not Resuscitate (DNR) status. Due to this failure, the facility failed to initiate CPR upon identification of the resident's cessation of breathing and heartbeat, resulting in the resident's death. Immediate Jeopardy was identified on 10/11/12, determined to exist on 09/29/12, and determined corrected on 10/02/12. The State Agency validated that the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 10/09/12; therefore, it was determined to be past non-compliance at the level of Past Immediate Jeopardy. (Refer to F281, F282 and F490)	F 000		
F 281 SS=J	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, record review, and review of the facility's policy/procedures, it was determined the facility failed to follow physician's orders for providing cardiopulmonary resuscitation (CPR) in the event of the residents change in condition, which included cessation of breathing and heart beat for one resident (#1), in the selected sample of five residents. The facility failed to ensure staff was knowledgeable and trained regarding their physician order policy and procedure to ensure residents' advanced directives and code status was followed. On 04/01/09, Resident #1 was	F 281	Past noncompliance: no plan of correction required.	

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F 281	Continued From page 2 determined to require CPR (full code) in the event cessation of breathing and heart beat occurred including a physician's order, dated 09/01-30/12, detailing Resident #1 had full code status. On 09/29/12 at 8:00 AM, Registered Nurse (RN) #1 assessed and determined that Resident #1 began to have seizures then ceased breathing and having a heart beat. The facility staff failed to accurately identify that Resident #1 was to have CPR initiated, per the physician's order, when LPN #1 reported to RN #1 that the resident was Do Not Resuscitate (DNR) status. Due to this failure, the facility failed to initiate CPR upon identification of the resident's cessation of breathing and heartbeat, resulting in the resident's death. Immediate Jeopardy was identified on 10/11/12, determined to exist on 09/29/12, and determined corrected on 10/02/12. The State Agency validated that the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 10/09/12; therefore, it was determined to be past non-compliance at the level of Past Immediate Jeopardy. (Refer to F282 and F490) Findings include: Review of facility's policy/procedure, "Physician Orders" (dated 08/31/12) revealed physician's orders are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Place the signed copy of the order in the designated page in the patient's medical record. Interview with Assistant Director of Nursing (ADON), on 10/17/12 at 9:30 AM, revealed the facility utilized the Lippincott's	F 281		

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F 281	Continued From page 3 Manual of nursing practice 7th Edition, a secondary resource, and firstly the facility used their own policy/procedures to guide their practice. An interview with the Attending Physician/Medical Director, on 10/10/12 at 3:00 PM, revealed staff are expected to look at the physician orders or the advanced directives for guidance related to full code and DNR status. A review of the facility policy/procedure for "Cardiopulmonary Resuscitation" (CPR), dated 12/15/10, revealed patients that are full code status or their code status are unknown that are without pulse and/or respirations receive basic life support to establish circulation and/or ventilation. Record review revealed the facility admitted Resident #1 on 07/23/02 with diagnoses to include Coronary Artery Disease, Dysphagia, Hypertension and Advanced Dementia. Review of physician order dated 09/01-30/12 revealed Resident #1 was determined to be a "Full Code/CPR" (start date 04/01/09). Review of a resident progress note, dated 09/26/12 at 12:45 PM, revealed there was a care plan meeting held and Resident #1's code status was reviewed, the resident was a full code, and no changes were made to the resident's physician order related to code status. Review of the investigation summary completed by the Director Nursing Services (DNS) dated 10/05/12, revealed the RN #1, on 09/29/12, assessed Resident #1 as demonstrating jerking movements and labored respirations. During the assessment, RN #1 determined the resident no longer had a pulse or respirations. During this time, LPN #1 checked the medical record to	F 281		

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F 281	Continued From page 4 determine code status. An interview with a Licensed Practical Nurse (LPN) #1, on 10/10/12 at 3:30 PM, revealed she looked at Resident #1's face sheet and the physician orders in the resident's medical record and found no code status information and there was also no advance directive. She stated she "assumed the resident was a no code." and informed RN #1 that the resident was DNR. Further review of the investigative summary revealed the LPN #1determined Resident #1 had a DNR status. The facility did not initiate CPR rather provided post mortem care and notifications were made of Resident #1's death. During the post event telephone review with the DNS, the RN supervisor reviewed the medical record and determined the resident had a physician's order for "full code" status requiring CPR to be initiated. An interview with Registered Nurse (RN) #1, on 10/10/12 at 2:55 PM, revealed Resident #1's physician order stated the resident was a "full code." It was only through conducting the audit of the medical record that she became aware the resident's physician orders were not carried out. An interview with the Director Nursing Services (DNS), on 10/11/12 at 9:00 AM, revealed LPN #1 failed to follow Resident #1's physician order for a full code and CPR was not performed and the resident died. After the resident's death, it was determined Resident #1 was a full code and LPN #1 was looking in the wrong location in the residents medical record for the DNR status, and this failure lead to the events of the resident not	F 281		

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F 281	Continued From page 5 receiving CPR. The DNS reported, LPN #1 did not follow the facility's policy/procedures for following physician orders because LPN #1 did not provide the resident with CPR. An interview with the Administrator, on 10/12/12 at 8:11 PM, revealed LPN #1 failed to follow the physician orders by not providing the resident with CPR, "it was basic nursing, that you check for the DNR status on the physician order not the face sheet." An interview with the Attending Physician/Medical Director, on 10/10/12 at 3:00 PM, revealed Resident #1 should have received CPR, because he/she was a full code. Staff are expected to look at the physician orders or the advanced directives for guidance. The facility had a failure in their identification system of where to look for the code status. Subsequently this failure resulted in the resident expiring and physician orders were not followed. The State Agency verified the facility implemented the following corrective actions which were completed on 10/01/2012. Thus verifying the facility was in compliance on 10/02/2012. **The facility implemented the following actions to correct the deficiency: *Audit of all current residents' charts to compare MD orders for code status, advance directives on file and yellow dot system of communicating code status; person responsible ANS/UM; completed 09/29/12. *Immediate education/performance improvement	F 281		

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F 281	Continued From page 6 action for the LN on correct way to identify code status in the medical record; person responsible DNS; completed 09/29/12. *Education of all LNs on CPR policies/procedures POC 601-04 and PRO 64001-02. All licensed nurses to receive education prior to start of their next scheduled shift; person responsible ADNS/SDC/UM; completed 09/29/12 on going; one nurse on vacation; one on FMLA. *PI team formed to address concerns including DDCO, DNS, ED, ADNS, MR, SSD, UMS, SDC, MD, Risk management. Ad hoc PI Discussion held and plan approved; person responsible team; completed 09/29/12. *Code blue drills to be conducted on all shifts over the next 72 hours with LNs to validate proper identification of code status and using the code blue drill checklist; person responsible SDC/ADNS/UM; completed 10/01/12. *LN orientation to include policies on emergency response and how to identify code status of residents. Orientation checklist to be reviewed by DNS/ADNS prior to nurse working on the floor; person responsible SDC/DNS/ADNS; completed, ongoing. *Contact family of affected resident with full disclosure; person responsible ED/RM; completed 10/01/12. *Contact MD of affected resident; person responsible DNS/ADNS; completed 09/29/12. *Validate all LNs current on CPR status; person	F 281		

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F 281	Continued From page 7 responsible SDC; completed 09/29/12. *Audit all emergency carts to validate proper supplies available per PRO 64001-02; person responsible ADNS; completed 09/29/12. *LNs to monitor emergency carts daily and validate supplies available per PRO 64001-02; person responsible LNs; completed 09/29/12 on going. *Report to PI monthly on progress of plan and monitoring; person responsible DNS/ADNS; initiate at next PI meeting to be held on 10/18/12. *Review of past 6 months of deaths in center to validate advance directive wishes honored; person responsible Medical records; completed 09/29/12. *Remove code status information from CNA assignment sheets; person responsible UMS/ADNS; completed 09/29/12. *Contact all residents/responsible parties to validate their wishes for code status are correctly noted in medical record; person responsible SSD; completed 09/30/12. *Educate IDT on process for reviewing code status with resident/responsible party with care plan reviews - PRO 61005; person responsible DDCO; completed 10/01/12. *Self report incident to OIG/DCBS; person responsible ED; completed 09/30/12. **The surveyor validated the corrective action	F 281		

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F 281	Continued From page 8 taken by the facility as follows: Record review for sampled residents revealed that the residents' advanced directives, living will and/or physician's order matched and were located in the medical record per the facility's policy and procedure. Observation of the resident's environment revealed the new code system identification in the resident's room matched that of the resident's medical record and physician's order. Record review validated the completion of all training of staff related to the new system and return demonstration to establish competency with following physician orders and care plan. Interviews with staff revealed that staff was knowledgeable and able to articulate their understanding of the new facility code status system. Each staff person was able to validate through return demonstration how to identify, accurately, a resident's code status. Each staff person understood what the code status meant and necessary action they were to take per the facility's policy and procedure. An interview with CNA #2, on 10/10/12 at 12:05 PM, revealed she was trained to notify the nurse when a resident has a change in condition. An interview with CNA #3, on 10/10/12 at 2:15 PM, revealed she was trained to report a change in the resident's condition to the nurse, then complete a "stop and watch." She stated, "If I cannot find a nurse, then I go find another nurse." An interview with CMA #1/CNA #1, on 10/09/12 at	F 281		

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F 281	Continued From page 9 4:10 PM, revealed "I look at the physician's orders, under Advanced Directives, and look for a yellow sticker for code status. " An interview with LPN #1, on 10/10/12 at 3:30 PM, revealed she was trained to look at the face sheet for DNR status, and the physician's orders related to code status. An interview with LPN #2, on 10/09/12 at 4:00 PM, revealed the yellow sticker means no code (DNR). She stated, "We go to the Advanced Directives and look for the order and then go to the physician's order and look at it, and look for the yellow dot. We had an inservice and mock code recently. I was not here, but I have been inserviced on the new system to identify who is a code or not." An interview with RN #1, on 10/10/12 at 2:55 PM, revealed "I received inservice training on DNR on the 30th and again during the first week of October, so there were two recent inservices on Advanced Directives/DNR. We also did code blue examples, and who was to respond. We did mock codes and we had to make decisions and determine what to do and determine the code status, DNR, etc. The yellow dot is on the record to tell you if a resident is a DNR, but you are expected to look at the physician's orders and the Advanced Directive." An interview with RN #2, on 10/09/12 at 4:20 PM, revealed the system was to look at the physician's order, look for the yellow dot, go to Advance Directives, and there will be DNR paperwork. The physician's order will say DNR or full code. There is a three step process to this to	F 281		

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F 281	Continued From page 10 ensure the correct thing is done. Inservice for all licensed staff occurred on 09/29/12. All charts were reviewed to ensure accuracy of DNR/code status, and there was a mock code blue also. An interview with RN #3 and LPN #3, on 10/12/12 at 6:45 PM, revealed they were inserviced on DNR care plan location and changes and updates as well as how to locate the DNR status on the care plan. An interview with Social Worker #1, on 10/12/12 at 5:00 PM, revealed the KRS law allows us to use the family who signs them in as the consent for treatment and decisions. If there are multiple children, it is whoever signs the resident in as the legal representative. We use the POA/medical and health care surrogate and the person who signs them in as the legal representative during the admission process, the person who signs all the admission papers and, of course, if the resident has the mental capacity, they can make that decision. Our care plan conferences are quarterly, but can be more often if there is a significant change, or if we are monitoring something or a problem comes up. The IDT team meetings are quarterly unless there is an issue that we are monitoring. The IDT meeting prepares us for the care plan meeting with the families. We have care plan meetings weekly on some residents and others are based on the MDS schedule, such as an assessment due or significant change comes up, so it is at least quarterly. Occasionally, the physician does attend, he is in the facility daily, but not all the time. The resident's cognitive status is looked at in the quarterly IDT meeting to determine if the resident can make their own decision. She stated	F 281		

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F 281	Continued From page 11 she did not know what period of time it is before the physician assessed the resident to determine if there was a significant change in condition. The IDT information is always communicated to the physician for significant change at least quarterly for any declines or improvements. An interview with the SDC, on 10/11/12 at 11:25 AM, revealed she was trained by the corporate staff related to her position. She stated she reviewed the DNR procedures and where to locate the DNR status on the chart. There was a file in her office related to testing and quizzes to verify who was knowledgeable. Prior to 09/29/12, I would do code blue drills facility wide and staff had to go through the procedure of location of DNR to CPR. This was done quarterly and never had issues with the mock codes. It is the facility's policy that the staff was not to work on the floor until their orientation checklist was completed. An interview with the DNS, on 10/11/12 at 9:00 AM, revealed staff were educated on 09/29/12 regarding code blue drills, going over district orientation provided by the facility. The re-training was very thorough. We did mock code drills which also demonstrated competency. When we send out letters, we send that we will discuss resident's code status. Social Services is now responsible to address the DNR/Advanced Directive. An interview with the Corporate Nurse, on 10/12/12 at 8:10 PM, revealed part of the system failure was that the nurse failed to correctly identify the resident ' s code status. She was educated properly and we have a witness who was in the class with her who validated that she	F 281		

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F 281	Continued From page 12 received the information where to look for the code status. The failure was that the family was not attending the care plan conferences and there was no communication between the family and the IDT team. We have corrected this problem by creating the letter which is mailed to the families when we invite them to the care plan meeting and it addresses the DNR/full code status. If families do not come to the meeting, the social worker is responsible to follow-up to ensure the accurate code/advance directive is in place. This is to be done at least quarterly with any care plan meeting and/or with significant change or any other need. The failure at the training level was no one was auditing the orientation checklist completed by the Staff Development Coordinator. Now, our system is that the DNS has to sign off on the orientation checklist before the staff is allowed to work on the floor. The nurse should not have been allowed to work on the floor with residents until she had the training on DNR/Advanced Directives. This is the first time we have identified a problem with our SDC training staff, in that she failed to have the checklist completed before the staff member worked on the floor, and that staff member functioned as a Supervisor. An interview with the physician, on 10/10/12 at 3:00 PM, revealed the facility did code blue runs where the staff had to respond to a code and demonstrate they knew what to do. I feel the facility did everything right after they had a failure in their identification system, the identification of where to look for the DNR status. All staff have been educated to look for the DNR status on the physician's orders, Advanced Directives, look for a yellow sticker, and it is on the care plan.	F 281		

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KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

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F 281	Continued From page 13 An interview with the Administrator, on 10/12/12 at 8:11 PM, revealed her duties included to ensure the proper functioning of the entire building. She stated they had a failure in their system due to not recognizing what the family's wishes were in relation to the resident's DNR status. She stated, "We need to improve on our communication with our residents' families. Now we have fixed this problem by having a letter sent out about the care plan conference which includes the resident's DNR/code status, and if the family does not come to the meeting then the Social Worker has to make a follow-up phone call. It is basic nursing to check for the DNR status on the physician's order, not the face sheet."	F 281		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedures, it was determined the facility failed to implement a plan of care related to a resident's full code status as the facility failed to provide cardiopulmonary resuscitation (CPR) in the event of the residents change in condition, which included cessation of breathing and heart beat for one resident (#1), in the selected sample of five residents. The facility	F 282	Past noncompliance: no plan of correction required.	

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F 282	Continued From page 14 failed to ensure staff provided CPR on 09/29/12 at 8:00 AM, for Resident #1 who was identified on his/her care plan dated 10/06/06 with the goal of "honor my wish" and the approach of "Full Code." when the resident begin to a have seizure, the experiencing cessation of breathing and heart beat. The facility failed to conduct CPR for Resident #1 resulting in the resident's death. Immediate Jeopardy was identified on 10/11/12, determined to exist on 09/29/12, and determined corrected on 10/02/12. The State Agency validated that the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 10/09/12; therefore, it was determined to be past non-compliance at the level of Past Immediate Jeopardy. (Refer to F281 and F490) Findings include: Review of the "Comprehensive Plan of Care" revealed a comprehensive plan of care is developed for each patient within 7 days after completing the comprehensive assessment. The care plan is re-evaluated and modified; as necessary to reflect changes in care, service and treatment; quarterly with assessment; and with significant change of condition assessment. Evaluate the care plan to ensure that it has; the patient progress toward the goal achievement is evaluated on or before target date and the status of progress toward goal achievement is documented in the progress notes as part of the patients medical record. For communication and implementation, communicate new or changed care plans to members of the interdisciplinary team and caregiver. Modify interventions	F 282		

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F 282	Continued From page 15 (resultant of change of condition or patient event) An interview with Social Worker #1, on 10/11/12 at 12:30 PM, revealed when families come in for care plan meetings we discuss the residents Do Not Resuscitate (DNR) status with them, to see if they want to make any changes. "In situations where the families do not come in for the care plan meetings we assume they do not want anything changed related to DNR/code status" Record review revealed the facility admitted Resident #1 on 07/23/02 with diagnoses to include Coronary Artery Disease, Dysphagia, Hypertension and Advanced Dementia. A review of the comprehensive care plan revealed Resident #1 was a "Full Code" this intervention dated 10/06/06 and the goal "honor my wishes" was dated 12/29/10 with a target date of review 11/15/12. Review of physician order dated 09/01-30/12 revealed an order for Resident #1 to have "Full Code/CPR" status detailing a start date of 04/01/09. Review of a resident progress note, dated 09/26/12 at 12:45 PM, revealed there was a care plan meeting held and Resident #1's code status was reviewed and remained a full code. Review of the investigation summary completed by the Director Nursing Services (DNS) dated 10/05/12, revealed the RN #1, on 09/29/12, assessed Resident #1 as demonstrating jerking movements and labored respirations. During the assessment, RN #1 determined the resident no longer had a pulse or respirations. During this time, LPN #1 checked the medical record to determine code status. Interview with a Licensed Practical Nurse (LPN) #1, on 10/10/12 at 3:30 PM, revealed she looked at Resident #1's face sheet and the physician orders in the resident's	F 282		

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F 282	Continued From page 16 medical record and found no code status information and there was also no advance directive. She stated she "assumed the resident was a no code." and informed RN #1 that the resident was DNR. Further review of the investigative summary revealed the LPN #1determined Resident #1 had a DNR status. The facility did not initiate CPR resulting in Resident #1's death. An interview with the Registered Nurse (RN) #1, on 10/10/12 at 2:55 PM, revealed Resident #1's physician order stated the resident was a "full code." It was only through conducting the audit of the medical record that she became aware the resident's physician orders and care plan were not carried out. An interview with the Social Worker #2, on 10/12/12 at 9:10 AM, revealed she was one of the interdisciplinary team members that participated in Resident #1's care plan meeting on 09/26/12. She stated the family was invited, but did not attend. The team met and discussed the resident's code status which remained a full code. No revisions were made to the residents care plan, and no communication was made with the family. An interview with Director Nursing Services (DNS), on 10/11/12 at 9:00 AM, revealed Resident #1's care plan said the resident was a full code and during the care plan meeting 09/26/12 the resident's family was invited but did not attend, therefore, no revisions were made to the care plan. Therefore, the facility failed to ensure that the resident's care plan was followed by failure to provide CPR on 09/29/12 per the	F 282		

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F 282	Continued From page 17 physician's orders and care plan. The State Agency verified the facility implemented the following corrective actions which were completed on 10/01/2012. Thus verifying the facility was in compliance on 10/02/2012. **The facility implemented the following actions to correct the deficiency: *Audit of all current residents' charts to compare MD orders for code status, advance directives on file and yellow dot system of communicating code status; person responsible ANS/UM; completed 09/29/12. *Immediate education/performance improvement action for the LN on correct way to identify code status in the medical record; person responsible DNS; completed 09/29/12. *Education of all LNs on CPR policies/procedures POC 601-04 and PRO 64001-02. All licensed nurses to receive education prior to start of their next scheduled shift; person responsible ADNS/SDC/UM; completed 09/29/12 on going; one nurse on vacation; one on FMLA. *PI team formed to address concerns including DDCO, DNS, ED, ADNS, MR, SSD, UMS, SDC, MD, Risk management. Ad hoc PI Discussion held and plan approved; person responsible team; completed 09/29/12. *Code blue drills to be conducted on all shifts over the next 72 hours with LNs to validate proper identification of code status and using the code blue drill checklist; person responsible	F 282		

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F 282	Continued From page 18 SDC/ADNS/UM; completed 10/01/12. *LN orientation to include policies on emergency response and how to identify code status of residents. Orientation checklist to be reviewed by DNS/ADNS prior to nurse working on the floor; person responsible SDC/DNS/ADNS; completed, ongoing. *Contact family of affected resident with full disclosure; person responsible ED/RM; completed 10/01/12. *Contact MD of affected resident; person responsible DNS/ADNS; completed 09/29/12. *Validate all LNs current on CPR status; person responsible SDC; completed 09/29/12. *Audit all emergency carts to validate proper supplies available per PRO 64001-02; person responsible ADNS; completed 09/29/12. *LNs to monitor emergency carts daily and validate supplies available per PRO 64001-02; person responsible LNs; completed 09/29/12 on going. *Report to PI monthly on progress of plan and monitoring; person responsible DNS/ADNS; initiate at next PI meeting to be held on 10/18/12. *Review of past 6 months of deaths in center to validate advance directive wishes honored; person responsible Medical records; completed 09/29/12. *Remove code status information from CNA	F 282		

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F 282	Continued From page 19 assignment sheets; person responsible UMS/ADNS; completed 09/29/12. *Contact all residents/responsible parties to validate their wishes for code status are correctly noted in medical record; person responsible SSD; completed 09/30/12. *Educate IDT on process for reviewing code status with resident/responsible party with care plan reviews - PRO 61005; person responsible DDCO; completed 10/01/12. *Self report incident to OIG/DCBS; person responsible ED; completed 09/30/12. **The surveyor validated the corrective action taken by the facility as follows: Record review for sampled residents revealed that the residents' advanced directives, living will and/or physician's order matched and were located in the medical record per the facility's policy and procedure. Observation of the resident's environment revealed the new code system identification in the resident's room matched that of the resident's medical record and physician's order. Record review validated the completion of all training of staff related to the new system and return demonstration to establish competency with following physician orders and care plan. Interviews with staff revealed that staff was knowledgeable and able to articulate their understanding of the new facility code status system. Each staff person was able to validate	F 282		

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F 282	Continued From page 20 through return demonstration how to identify, accurately, a resident's code status. Each staff person understood what the code status meant and necessary action they were to take per the facility's policy and procedure. An interview with CNA #2, on 10/10/12 at 12:05 PM, revealed she was trained to notify the nurse when a resident has a change in condition. An interview with CNA #3, on 10/10/12 at 2:15 PM, revealed she was trained to report a change in the resident's condition to the nurse, then complete a "stop and watch." She stated, "If I cannot find a nurse, then I go find another nurse." An interview with CMA #1/CNA #1, on 10/09/12 at 4:10 PM, revealed "I look at the physician's orders, under Advanced Directives, and look for a yellow sticker for code status. " An interview with LPN #1, on 10/10/12 at 3:30 PM, revealed she was trained to look at the face sheet for DNR status, and the physician's orders related to code status. An interview with LPN #2, on 10/09/12 at 4:00 PM, revealed the yellow sticker means no code (DNR). She stated, "We go to the Advanced Directives and look for the order and then go to the physician's order and look at it, and look for the yellow dot. We had an inservice and mock code recently. I was not here, but I have been inserviced on the new system to identify who is a code or not." An interview with RN #1, on 10/10/12 at 2:55 PM, revealed "I received inservice training on DNR on	F 282		

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F 282	Continued From page 21 the 30th and again during the first week of October, so there were two recent inservices on Advanced Directives/DNR. We also did code blue examples, and who was to respond. We did mock codes and we had to make decisions and determine what to do and determine the code status, DNR, etc. The yellow dot is on the record to tell you if a resident is a DNR, but you are expected to look at the physician's orders and the Advanced Directive." An interview with RN #2, on 10/09/12 at 4:20 PM, revealed the system was to look at the physician's order, look for the yellow dot, go to Advance Directives, and there will be DNR paperwork. The physician's order will say DNR or full code. There is a three step process to this to ensure the correct thing is done. Inservice for all licensed staff occurred on 09/29/12. All charts were reviewed to ensure accuracy of DNR/code status, and there was a mock code blue also. An interview with RN #3 and LPN #3, on 10/12/12 at 6:45 PM, revealed they were inserviced on DNR care plan location and changes and updates as well as how to locate the DNR status on the care plan. An interview with Social Worker #1, on 10/12/12 at 5:00 PM, revealed the KRS law allows us to use the family who signs them in as the consent for treatment and decisions. If there are multiple children, it is whoever signs the resident in as the legal representative. We use the POA/medical and health care surrogate and the person who signs them in as the legal representative during the admission process, the person who signs all the admission papers and, of course, if the	F 282		

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F 282	Continued From page 22 resident has the mental capacity, they can make that decision. Our care plan conferences are quarterly, but can be more often if there is a significant change, or if we are monitoring something or a problem comes up. The IDT team meetings are quarterly unless there is an issue that we are monitoring. The IDT meeting prepares us for the care plan meeting with the families. We have care plan meetings weekly on some residents and others are based on the MDS schedule, such as an assessment due or significant change comes up, so it is at least quarterly. Occasionally, the physician does attend, he is in the facility daily, but not all the time. The resident's cognitive status is looked at in the quarterly IDT meeting to determine if the resident can make their own decision. She stated she did not know what period of time it is before the physician assessed the resident to determine if there was a significant change in condition. The IDT information is always communicated to the physician for significant change at least quarterly for any declines or improvements. An interview with the SDC, on 10/11/12 at 11:25 AM, revealed she was trained by the corporate staff related to her position. She stated she reviewed the DNR procedures and where to locate the DNR status on the chart. There was a file in her office related to testing and quizzes to verify who was knowledgeable. Prior to 09/29/12, I would do code blue drills facility wide and staff had to go through the procedure of location of DNR to CPR. This was done quarterly and never had issues with the mock codes. It is the facility's policy that the staff was not to work on the floor until their orientation checklist was completed.	F 282		

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F 282	Continued From page 23 An interview with the DNS, on 10/11/12 at 9:00 AM, revealed staff were educated on 09/29/12 regarding code blue drills, going over district orientation provided by the facility. The re-training was very thorough. We did mock code drills which also demonstrated competency. When we send out letters, we send that we will discuss resident's code status. Social Services is now responsible to address the DNR/Advanced Directive. An interview with the Corporate Nurse, on 10/12/12 at 8:10 PM, revealed part of the system failure was that the nurse failed to correctly identify the resident ' s code status. She was educated properly and we have a witness who was in the class with her who validated that she received the information where to look for the code status. The failure was that the family was not attending the care plan conferences and there was no communication between the family and the IDT team. We have corrected this problem by creating the letter which is mailed to the families when we invite them to the care plan meeting and it addresses the DNR/full code status. If families do not come to the meeting, the social worker is responsible to follow-up to ensure the accurate code/advance directive is in place. This is to be done at least quarterly with any care plan meeting and/or with significant change or any other need. The failure at the training level was no one was auditing the orientation checklist completed by the Staff Development Coordinator. Now, our system is that the DNS has to sign off on the orientation checklist before the staff is allowed to work on the floor. The nurse should not have been allowed to work on the floor with residents until she had the training on DNR/Advanced	F 282		

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F 282	Continued From page 24 Directives. This is the first time we have identified a problem with our SDC training staff, in that she failed to have the checklist completed before the staff member worked on the floor, and that staff member functioned as a Supervisor. An interview with the physician, on 10/10/12 at 3:00 PM, revealed the facility did code blue runs where the staff had to respond to a code and demonstrate they knew what to do. I feel the facility did everything right after they had a failure in their identification system, the identification of where to look for the DNR status. All staff have been educated to look for the DNR status on the physician's orders, Advanced Directives, look for a yellow sticker, and it is on the care plan. An interview with the Administrator, on 10/12/12 at 8:11 PM, revealed her duties included to ensure the proper functioning of the entire building. She stated they had a failure in their system due to not recognizing what the family's wishes were in relation to the resident's DNR status. She stated, "We need to improve on our communication with our residents' families. Now we have fixed this problem by having a letter sent out about the care plan conference which includes the resident's DNR/code status, and if the family does not come to the meeting then the Social Worker has to make a follow-up phone call. It is basic nursing to check for the DNR status on the physician's order, not the face sheet."	F 282		
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	F 490		

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F 490	Continued From page 25 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 and record review, and review of the Administrator's job description, it was determined the facility failed to administer in a manner which enabled it to use it's resources effectively and efficiently to attain or maintain the highest practical, physical, mental, and psychosocial well-being for one resident (#1) in the selected sample of five residents. The facility failed to have an effective system in place and to ensure staff was trained and knowledgeable to accurately identify residents' code status in the event of cardiac and respiratory arrest and initiate as appropriate. Upon admission, the facility detailed within Resident #1's medical record that Resident #1 was identified as having full code status (to be provided Cardiopulmonary Resuscitation (CPR) in the event of cardiac and respiratory arrest). On 09/29/12 at 8:00 AM, Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 assessed Resident #1 as being without a heartbeat and respirations. These facility staff failed to initiate CPR per the resident's wishes, physician's order and care plan. This failure resulted in Resident #1's death. LPN #1 was unaware of the location to identify accurately a resident's code status despite having had training. The facility was unable to provide evidence of a system to ensure staff was knowledgeable and competent after being provided training.	F 490	Past noncompliance: no plan of correction required.	

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F 490	Continued From page 26 Immediate Jeopardy was identified on 10/11/12, determined to exist on 09/29/12, and determined corrected on 10/02/12. The State Agency validated that the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 10/09/12; therefore, it was determined to be past non-compliance at the level of Past Immediate Jeopardy. (Refer to F281 and F282) Findings include: A review of the job description for "Administration" (no date), revealed the Administrator is responsible for the efficient and profitable operation of the facility, facility compliance with corporate policies and State and Federal rules and regulations, and providing the highest quality of care possible. Manages the day-to-day operations of the facility. Implements control systems to ensure accountability of all departments. Monitors performance for achievements of goals and for improvement, and takes corrective action when necessary. Ensures all employees receive orientation and ongoing training to meet the quality goals of the organization. Monitors facilities' staff in the execution of their compliance-related functions. A review of the facility policy/procedure for "Cardiopulmonary Resuscitation" (CPR), dated 12/15/10, revealed patients that are full code status or their code status are unknown that are without pulse and/or respirations receive basic life support to establish circulation and/or ventilation. Record review revealed the facility admitted	F 490		

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F 490	Continued From page 27 Resident #1 on 07/23/02 with diagnoses to include Coronary Artery Disease, Dysphagia, Hypertension and Advanced Dementia. Review of physician order dated 09/01-30/12 revealed Resident #1 was determined to be a "Full Code/CPR" (start date 04/01/09). Review of a resident progress note dated 09/26/12 at 12:45 PM, revealed there was a care plan meeting held and Resident #1's advanced directive was reviewed, the resident was a full code, and no changes were made to the resident's care plan. A review of the investigation summary completed by the Director Nursing Services (DNS) dated 10/05/12 revealed on 09/29/12 at 8:00 AM, facility staff did not perform CPR per the resident's physician order or care plan. LPN #1 failed to accurately identify the resident's code status in the medical record reporting to RN #1 that the resident was a "do not resuscitate (DNR)" status. Licensed Practical Nurse (LPN) #1, on 10/10/12 at 3:30 PM, revealed she looked at Resident #1's face sheet and the physician orders in the resident's medical record and found no code status information and there was also no advance directive. She stated she "assumed the resident was a no code." and informed RN #1 that the resident was DNR. Interview with the Staff Development Coordinator, on 10/11/12 at 11:25 AM, revealed that while LPN #1 had been trained on code status, she did not perform competency testing of LPN #1 after the training was completed. An interview with the Administrator, on 10/12/12 at 8:11 PM, revealed she was responsible to ensure the proper functioning on the entire building. There was a failure in facility's system	F 490		

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F 490	Continued From page 28 related to honoring the residents advanced directives. The staff should have coded Resident #1 as directed by the physician order "Full Code." There was no excuse for this failure, it was basic nursing, and staff are to check the the DNR status on the physician order, not the face sheet as LPN #1 did. An interview with the Corporate Nurse, on 10/12/12 at 8:10 PM, revealed part of the facility's system failure was that staff failed to correctly identify the residents code status and LPN #1 was trained on where to correctly locate the code status in the residents medical record, however she did not. The State Agency verified the facility implemented the following corrective actions which were completed on 10/01/2012. Thus verifying the facility was in compliance on 10/02/2012. **The facility implemented the following actions to correct the deficiency: *Audit of all current residents' charts to compare MD orders for code status, advance directives on file and yellow dot system of communicating code status; person responsible ANS/UM; completed 09/29/12. *Immediate education/performance improvement action for the LN on correct way to identify code status in the medical record; person responsible DNS; completed 09/29/12. *Education of all LNs on CPR policies/procedures POC 601-04 and PRO 64001-02. All licensed nurses to receive education prior to start of their	F 490		

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F 490	Continued From page 29 next scheduled shift; person responsible ADNS/SDC/UM; completed 09/29/12 on going; one nurse on vacation; one on FMLA. *PI team formed to address concerns including DDCO, DNS, ED, ADNS, MR, SSD, UMS, SDC, MD, Risk management. Ad hoc PI Discussion held and plan approved; person responsible team; completed 09/29/12. *Code blue drills to be conducted on all shifts over the next 72 hours with LNs to validate proper identification of code status and using the code blue drill checklist; person responsible SDC/ADNS/UM; completed 10/01/12. *LN orientation to include policies on emergency response and how to identify code status of residents. Orientation checklist to be reviewed by DNS/ADNS prior to nurse working on the floor; person responsible SDC/DNS/ADNS; completed, ongoing. *Contact family of affected resident with full disclosure; person responsible ED/RM; completed 10/01/12. *Contact MD of affected resident; person responsible DNS/ADNS; completed 09/29/12. *Validate all LNs current on CPR status; person responsible SDC; completed 09/29/12. *Audit all emergency carts to validate proper supplies available per PRO 64001-02; person responsible ADNS; completed 09/29/12. *LNs to monitor emergency carts daily and	F 490		

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F 490	Continued From page 30 validate supplies available per PRO 64001-02; person responsible LNs; completed 09/29/12 on going. *Report to PI monthly on progress of plan and monitoring; person responsible DNS/ADNS; initiate at next PI meeting to be held on 10/18/12. *Review of past 6 months of deaths in center to validate advance directive wishes honored; person responsible Medical records; completed 09/29/12. *Remove code status information from CNA assignment sheets; person responsible UMS/ADNS; completed 09/29/12. *Contact all residents/responsible parties to validate their wishes for code status are correctly noted in medical record; person responsible SSD; completed 09/30/12. *Educate IDT on process for reviewing code status with resident/responsible party with care plan reviews - PRO 61005; person responsible DDCO; completed 10/01/12. *Self report incident to OIG/DCBS; person responsible ED; completed 09/30/12. **The surveyor validated the corrective action taken by the facility as follows: Record review for sampled residents revealed that the residents' advanced directives, living will and/or physician's order matched and were located in the medical record per the facility's policy and procedure. Observation of the	F 490		

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F 490	Continued From page 31 resident's environment revealed the new code system identification in the resident's room matched that of the resident's medical record and physician's order. Record review validated the completion of all training of staff related to the new system and return demonstration to establish competency with following physician orders and care plan. Interviews with staff revealed that staff was knowledgeable and able to articulate their understanding of the new facility code status system. Each staff person was able to validate through return demonstration how to identify, accurately, a resident's code status. Each staff person understood what the code status meant and necessary action they were to take per the facility's policy and procedure. An interview with CNA #2, on 10/10/12 at 12:05 PM, revealed she was trained to notify the nurse when a resident has a change in condition. An interview with CNA #3, on 10/10/12 at 2:15 PM, revealed she was trained to report a change in the resident's condition to the nurse, then complete a "stop and watch." She stated, "If I cannot find a nurse, then I go find another nurse." An interview with CMA #1/CNA #1, on 10/09/12 at 4:10 PM, revealed "I look at the physician's orders, under Advanced Directives, and look for a yellow sticker for code status. " An interview with LPN #1, on 10/10/12 at 3:30 PM, revealed she was trained to look at the face sheet for DNR status, and the physician's orders	F 490		

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F 490	Continued From page 32 related to code status. An interview with LPN #2, on 10/09/12 at 4:00 PM, revealed the yellow sticker means no code (DNR). She stated, "We go to the Advanced Directives and look for the order and then go to the physician's order and look at it, and look for the yellow dot. We had an inservice and mock code recently. I was not here, but I have been inserviced on the new system to identify who is a code or not." An interview with RN #1, on 10/10/12 at 2:55 PM, revealed "I received inservice training on DNR on the 30th and again during the first week of October, so there were two recent inservices on Advanced Directives/DNR. We also did code blue examples, and who was to respond. We did mock codes and we had to make decisions and determine what to do and determine the code status, DNR, etc. The yellow dot is on the record to tell you if a resident is a DNR, but you are expected to look at the physician's orders and the Advanced Directive." An interview with RN #2, on 10/09/12 at 4:20 PM, revealed the system was to look at the physician's order, look for the yellow dot, go to Advance Directives, and there will be DNR paperwork. The physician's order will say DNR or full code. There is a three step process to this to ensure the correct thing is done. Inservice for all licensed staff occurred on 09/29/12. All charts were reviewed to ensure accuracy of DNR/code status, and there was a mock code blue also. An interview with RN #3 and LPN #3, on 10/12/12 at 6:45 PM, revealed they were inserviced on	F 490		

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F 490	Continued From page 33 DNR care plan location and changes and updates as well as how to locate the DNR status on the care plan. An interview with Social Worker #1, on 10/12/12 at 5:00 PM, revealed the KRS law allows us to use the family who signs them in as the consent for treatment and decisions. If there are multiple children, it is whoever signs the resident in as the legal representative. We use the POA/medical and health care surrogate and the person who signs them in as the legal representative during the admission process, the person who signs all the admission papers and, of course, if the resident has the mental capacity, they can make that decision. Our care plan conferences are quarterly, but can be more often if there is a significant change, or if we are monitoring something or a problem comes up. The IDT team meetings are quarterly unless there is an issue that we are monitoring. The IDT meeting prepares us for the care plan meeting with the families. We have care plan meetings weekly on some residents and others are based on the MDS schedule, such as an assessment due or significant change comes up, so it is at least quarterly. Occasionally, the physician does attend, he is in the facility daily, but not all the time. The resident's cognitive status is looked at in the quarterly IDT meeting to determine if the resident can make their own decision. She stated she did not know what period of time it is before the physician assessed the resident to determine if there was a significant change in condition. The IDT information is always communicated to the physician for significant change at least quarterly for any declines or improvements.	F 490		

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F 490	Continued From page 34 An interview with the SDC, on 10/11/12 at 11:25 AM, revealed she was trained by the corporate staff related to her position. She stated she reviewed the DNR procedures and where to locate the DNR status on the chart. There was a file in her office related to testing and quizzes to verify who was knowledgeable. Prior to 09/29/12, I would do code blue drills facility wide and staff had to go through the procedure of location of DNR to CPR. This was done quarterly and never had issues with the mock codes. It is the facility's policy that the staff was not to work on the floor until their orientation checklist was completed. An interview with the DNS, on 10/11/12 at 9:00 AM, revealed staff were educated on 09/29/12 regarding code blue drills, going over district orientation provided by the facility. The re-training was very thorough. We did mock code drills which also demonstrated competency. When we send out letters, we send that we will discuss resident's code status. Social Services is now responsible to address the DNR/Advanced Directive. An interview with the Corporate Nurse, on 10/12/12 at 8:10 PM, revealed part of the system failure was that the nurse failed to correctly identify the resident ' s code status. She was educated properly and we have a witness who was in the class with her who validated that she received the information where to look for the code status. The failure was that the family was not attending the care plan conferences and there was no communication between the family and the IDT team. We have corrected this problem by creating the letter which is mailed to the families when we invite them to the care plan meeting and	F 490		

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F 490	Continued From page 35 it addresses the DNR/full code status. If families do not come to the meeting, the social worker is responsible to follow-up to ensure the accurate code/advance directive is in place. This is to be done at least quarterly with any care plan meeting and/or with significant change or any other need. The failure at the training level was no one was auditing the orientation checklist completed by the Staff Development Coordinator. Now, our system is that the DNS has to sign off on the orientation checklist before the staff is allowed to work on the floor. The nurse should not have been allowed to work on the floor with residents until she had the training on DNR/Advanced Directives. This is the first time we have identified a problem with our SDC training staff, in that she failed to have the checklist completed before the staff member worked on the floor, and that staff member functioned as a Supervisor. An interview with the physician, on 10/10/12 at 3:00 PM, revealed the facility did code blue runs where the staff had to respond to a code and demonstrate they knew what to do. I feel the facility did everything right after they had a failure in their identification system, the identification of where to look for the DNR status. All staff have been educated to look for the DNR status on the physician's orders, Advanced Directives, look for a yellow sticker, and it is on the care plan. An interview with the Administrator, on 10/12/12 at 8:11 PM, revealed her duties included to ensure the proper functioning of the entire building. She stated they had a failure in their system due to not recognizing what the family's wishes were in relation to the resident's DNR status. She stated, "We need to improve on our	F 490		

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F 490	Continued From page 36 communication with our residents' families. Now we have fixed this problem by having a letter sent out about the care plan conference which includes the resident's DNR/code status, and if the family does not come to the meeting then the Social Worker has to make a follow-up phone call. It is basic nursing to check for the DNR status on the physician's order, not the face sheet."	F 490		