

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

Second SOD

PRINTED: 06/04/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED JUN - 5 2012 04/26/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40401 Division of Health Care Southern Enforcement Branch	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROBABLE CAUSE OF DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An abbreviated standard survey (KY18222) was conducted on 04/25-26/12. The complaint was unsubstantiated with unrelated deficient practice identified at "D" level.	F 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	<b>F157</b>  On 4/19/12 after being told about the condition of resident #1 DON, Miranda Ruggles RN evaluated the resident and then directed Nurse RN #1 to call physician and family, and notify them about change in condition regarding the "popping" noise. RN #1 has been terminated and is no longer an employee of Charleston Health Care Center.  RN #1 was given a direct order by DON Miranda Ruggles on 4/19/12 to call the physician and family. M.Cox LPN #4 overheard that order, as well as J.Hawkins LPN. J. Hawkins was not interview by state surveyor during 4/25-4/26/12 complaint visit. Even though Nurse #1 was in orientation this was the duty of RN #1 and within her scope of practice.  Pursuant to the direction of the Administrator Marlin Sparks immediate intense education of all Licensed Practical Nurses and Registered Nurses started on Friday April 27, 2012.  Education was taught on abuse reports, abuse reporting, physician notification and resident rights. Each nurse was given handouts pertaining to physician notification and documentation, incident reports and resident rights.  To become more proficient each participant successfully completed "mock"	

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

*Mal K. [Signature]*

TITLE

P.R.S.

(X6) DATE

6-5-12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to promptly notify the resident's physician when an incident or accident occurred which had the potential for requiring a need to alter the resident's medical treatment significantly for one of three sampled residents (Resident #1). A review of facility records revealed on 04/19/12, while providing care for Resident #1, facility staff heard a "popping" noise and the resident's physician was not notified. Further record review revealed on 04/20/12, facility staff assessed Resident #1 to have a "possible" hip fracture on the right side, and a "possible" fracture present to the left upper arm. At that time, Resident #1's physician was notified, the resident was sent to the Emergency Room for evaluation, and was admitted to the hospital with diagnoses that included Right Hip Fracture, Left Humerus Fracture, Severe Osteoporosis, and Advanced Rheumatoid Arthritis.  The findings include:  Review of the facility policy titled Change in a Resident's Condition or Status, revised April 2011, revealed facility staff was to promptly notify the resident's physician when an incident/accident occurred involving a resident. Further review of facility policy revealed staff was to notify the resident's physician when an incident or accident occurred which altered the resident's medical treatment significantly.	F 157	incident that they worked through start through finish. Including all documentation to: physician, family, and Charleston Health Care Center administration. Education was concluded after completion date of April 30, 2012. Education was administered by Chris Brown Compliance Officer, Miranda Ruggles DON, Joyce Andros RN Cooperate Nursing Consultant, and Jill Brown Executive Director.  Charleston Health Care Center Director of Nursing Miranda Ruggles, RN and Joyce Andros RN Cooperate Nursing Consultant created an Incident Documentation Log, (please see attachment). The goal of the log is to put solid systemic changes for efficiency as well as Quality Assurance.  In addition on May 11, 2012 continued education was provided for all Licensed Practical Nurses, and Registered Nurses. A kit was presented to each nurse with material pertaining to physician notification, change in resident condition, physician notification and documentation, incident reports, incident documentation log, medication error report Policy and procedure on skin integrity issues, skin assessment policy, staging of skin and definitions of skin/wound tissue, identifying un-stage able pressure ulcers, measuring pressure ulcers, assessment wound tissue, assessing drainage and order, wounds surrounding skin color. Education led by Miranda Ruggles DON, and Chris Brown Compliance Officer.  On April 27, 2012 the physician notification policy following a fall or suspected fall as well as the		

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F 157	<p>Continued From page 2</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 04/06/12, with diagnoses that included a History of Pathological Fractures, Osteoporosis, Rheumatoid Arthritis, Malnutrition, and Wasting Disease. Review of the admission Minimum Data Set (MDS) assessment dated 04/16/12, revealed the facility had assessed the resident to require total assistance from staff for bed mobility, dressing, and bathing.</p> <p>A review of the nurse's notes for Resident #1 dated 04/19/12, at 2:30 PM, revealed Registered Nurse (RN) #1 had documented that while care was being provided for the resident facility staff had heard a "popping" noise. Further review of RN #1's documentation revealed during her first assessment immediately following the "popping" noise the resident's hip joints looked asymmetrical, however, the resident lifted his/her right leg and placed it in the middle of the resident's bed, and the symmetry returned to Resident #1's hip joints. Based on a review of documentation in the nurse's notes, the resident's physician was not notified of the incident at that time.</p> <p>An interview with Certified Nurse Aide (CNA) #1 on 04/26/12, at 12:22 PM, revealed she and three additional staff members assisted with providing incontinence care to Resident #1 on 04/19/12. CNA #1 stated staff used a sheet to turn the resident while providing the care and when the resident was turned to the left side, the CNAs present in the room heard two "popping" noises. Further interview revealed immediately after hearing the "popping" noises, the resident wasn't moved again and the nurse was notified.</p>	F 157	<p>DEFICIENCY</p> <p>accident/incident report were revised. The Incident Documentation Log was started on 5/11/12 and will also be utilized for quality assurance purposes.</p> <p>Corrective action for the resident found to be affected by the deficient practice was not accomplished because the resident had been discharged from the facility on 4/20/12. However corrective action for all other residents, even though they had not been affected by the alleged deficient practice was completed by May 11, 2012. Charleston Health Care Center took immediate action when OIG brought forth concern relating to regulation 483.10. The facility started by immediately training all key employees under the direction of Marlin Sparks, Administrator. In addition an Incident Documentation Log was developed to help ensure compliance, and quality assurance. DON, and or designee are checking 7 days per week indefinitely to confirm accuracy of physician notification, and compliance of the incident log relating to regulation 483.10. RN #1 employment was terminated, and LPN #4 and LPN that was not interview by state surveyor during complaint visit on 4/25/12-4/26/12 were counseled.</p> <p>Charleston Health Care Center plans to identify other residents having the potential to be affected by the same alleged deficient practice by utilizing the Incident Documentation Log to the fullest potential. Incident Documentation Log will be checked 7 times per week indefinitely to ensure compliance, and quality assurance.</p>		

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F 157	<p>Continued From page 3</p> <p>According to CNA #1, the nurse came into Resident #1's room and assessed the resident. CNA #1 stated the resident didn't show any new signs of pain at that time.</p> <p>An interview with RN #1 on 04/26/12, at 12:15 PM, confirmed she had assessed Resident #1 on 04/19/12, immediately after staff had reported hearing a "popping" noise while providing care to the resident. Continued interview revealed upon initial assessment Resident #1's hips looked odd, but when the resident lifted his/her leg independently, "it looked ok." Further interview revealed RN #1 stated she was a new employee in orientation, therefore she immediately notified the charge nurse, Director of Nursing (DON), and the facility's Nurse Consultant, and Resident #1 was also assessed by them. Interview with RN #1 confirmed she did not notify the resident's physician of the incident. RN #1 stated she didn't call Resident #1's physician because she had been employed at the facility for only a week and remained in orientation.</p> <p>An interview with Licensed Practical Nurse (LPN) #4 on 04/26/12, at 12:55 PM, revealed she was the charge nurse on 04/19/12, when the incident involving Resident #1 occurred. Further interview revealed she had entered the resident's room with the Director of Nursing (DON), assessed Resident #1, and stated the resident's hips looked "fine." LPN #4 stated she observed no redness or edema and the resident had no signs of pain or discomfort. LPN #4 also stated she did not contact Resident #1's physician because she did not see any change in the resident's condition.</p>	F 157	<p>In addition DON, and or designee with check all incident reports to confirm documentation, and regulations as set forth in 483.10</p> <p>Medical Director and Physician Consultation will be included in compliance and quality assurance weekly.</p> <p>Charleston Health Care Center has set forth systemic change which include intense education, revision of policy and procedures, given all nurses the appropriate tools, developed a new documentation log, planning and discussing with the Medical Director, and the Physician Consult as well oversee the documentation to ensure that the deficient practice does not recur.</p> <p>Charleston Health Care Center plans to monitor its performance 7 times weekly indefinitely to ensure that substantial solutions are being meet by reviewing the incident documentation log, and reviewing all incident reports 5 times per week indefinitely.</p> <p>The facility was in substantial compliance on May 11, 2012.</p>	

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F.157	<p>Continued From page 4</p> <p>An interview with the facility Nurse Consultant on 04/26/12, at 4:35 PM, revealed she assessed Resident #1 on 04/19/12, immediately after staff reported hearing a "popping" noise and stated she did not see any visible signs of bone/joint abnormalities at the time of her assessment. Further interview revealed she did not notify Resident #1's physician of the incident.</p> <p>An interview with the DON on 04/26/12, at 4:00 PM, confirmed she assessed Resident #1 on 04/19/12, immediately after staff reported hearing a "popping" noise. Further interview revealed she saw nothing abnormal about the resident during her assessment and did not direct facility staff to contact the resident's primary physician. Continued interview with the DON revealed, "Looking back on this incident and the resident's history we should have called the doctor after hearing a popping noise."</p> <p>An interview with Physician #1 on 04/26/12, at 3:45 PM, revealed he should have been notified promptly by facility staff when they heard a "popping" noise while providing care. Physician #1 continued to state facility staff was aware of the resident's history of pathological fractures and he would have expected to have been notified of this incident.</p>	F.157			