

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

PRINTED: 10/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2010
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NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1606 SOUTH DIXIE STREET HORSE CAVE, KY 42749
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A standard health survey was conducted 09/21/10 through 09/23/10 and a Life Safety Code survey was conducted on 09/23/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be recommended for imposition. KY00014945 was substantiated based on the deficiency cited at 483.25 Quality of Care. This was a Nursing Home Initiative survey with entrance on Tuesday, 09/21/10 at 5:45am.	F 000	The charts were reviewed for resident #13 and #19. The Resuscitation Designation Form was reviewed and the wishes of the resident were conveyed to the MD. A 100% audit of charts was completed on 10/14/10 by SSD to ensure the Resuscitation Designation Form was present, completed and the MD had signed the acknowledgment. The chart was reviewed and labeled per policy.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES. The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure formulated advanced directives were documented in the clinical record for two (2) of twenty-two (22) sampled residents. Resident #9's physician ordered a Do Not Resuscitate when the resident had documented the wish for a Full Code. Resident #13 was admitted with a documented wish for Do Not Resuscitate and the facility's order had expired several months prior. The findings include:	F 155	Nursing staff were re-educated on the Resuscitation Designation Policy on 10/15/10 by the SSD. Per policy all residents must designate their wishes regarding resuscitation upon admission and may change this at any time. The MD is made aware of the wishes by phone or they acknowledge their notification by signing the Resuscitation Designation Form. Our policy does not require there be a MD order therefore we have notified all MD's that the order will be removed from the physician order sheet.	10/26/10 10-28-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10-15-10
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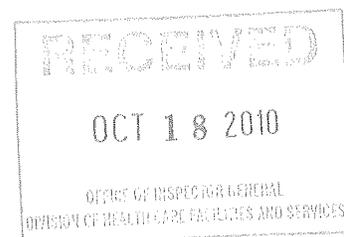
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCT 18 2010

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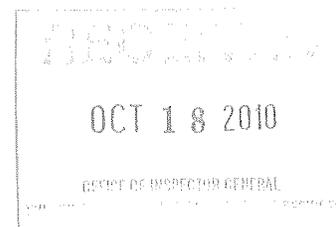
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F 155	Continued From page 1 Review of the facility's policy for Designation of Resuscitation Status, dated 06/01/09, revealed the resident's resuscitation status would be documented in the clinical record. Review of the clinical record for Resident #9 revealed the resident/family had designated the resident be a full code and this document was signed by the physician; however, the physician had written an order for Do Not Resuscitate. Review of the clinical record for Resident #13 revealed the resident/family had designated the resident's resuscitation status as Do Not Resuscitate. The facility dropped the order off of the renewal orders signed by the physician every sixty (60) days and there was no order for the Do Not Resuscitate status. Interview with Registered Nurse (RN) #1 on 09/21/10 at 1:40pm, revealed the facility normally obtains orders from the physician to reflect the resident's resuscitation status, and carries those orders as active current orders. She stated the incorrect order for Resident #9 and the missing order for Resident #13 were just missed by nursing. Interview with the Director of Nursing (DON) on 09/23/10 at 3:15pm revealed resident resuscitation orders should be accurate and in place.	F 155	All charts are labeled with a red dot if the resident has designated their code status be DNR. The front cover of the chart contains a label as DNR or Full Code based on resident designation. SSD will audit all resident records every six month to ensure the Resuscitation Designation Form is complete, the physician acknowledgment is present and the chart is labeled appropriately. These audits will be reported to the QA Committee for review.		
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	F 157			



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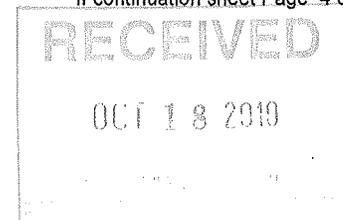
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F 157	<p>Continued From page 2</p> <p>or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, 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> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined the facility failed to notify the physician for one (1) resident (#12) of the twenty-two (22) sampled residents. Resident #12 had dialysis recommendations to decrease a fluid restriction from 2000cc to 1500cc and elevated blood pressures due to fluid gains between dialysis treatments. In addition,</p>	F 157	<p>MD for resident #12 was given an update on the residents condition by nursing on 9/22/10. An order was obtained for the fluid restriction and renal diet. The MD was made aware of the residents past non-compliance.</p> <p>The DON or designee reviewed the 24 hours reports, dialysis communication reports, RD reports, pharmacy reviews and nurse notes for the last 3 months to determine if any other changes in condition that had not been properly reported to the MD.</p> <p>Licensed staff were inserviced on 10/15/10 by DON on physician notification of change. A copy of the policy was given to each nurse and posted on the nurse station for review.</p> <p>The DON or designee will review 24 hour report sheets, incident reports, communication reports, consultation reports weekly for 4 weeks then monthly to ensure that nurses are adhering to the policy.</p>	10-26-10 10-29-10	



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F 157	Continued From page 3 Resident #12 had a dietary recommendation for a renal diet and was noncompliant with the fluid restriction. The findings include: Review of Resident #12's clinical record revealed an admission date of 09/16/10 with diagnosis of End Stage Renal Disease. The physician orders dated 09/16/10 indicated the resident was to receive dialysis three times a week on Monday, Wednesday and Fridays. The resident was to receive a regular diet with a 2000cc fluid restriction. The resident's baseline blood pressure was documented as 162/84 on 09/16/10. Review of the dialysis report sheets dated 09/17/10, indicated the resident's blood pressure was 170/79 before dialysis, and 106/63, a "complication after treatment of hypotension (low blood pressure) due to large fluid gains between treatments". The dialysis unit recommended decreasing the fluid restriction to 1500cc daily. The facility staff documented the resident's blood pressure on 09/18/10 as 220/86; however, there was no evidence the facility notified the physician. The intake record for Resident #12 on 09/19/10 revealed the resident exceeded the 2000cc fluid restriction by 550cc's. Review of the medical record revealed no evidence the facility notified the physician. In addition, a second report sheet dated 09/20/10 indicated the resident's blood pressure before dialysis treatment was 193/82 and after dialysis it dropped to 99/50, a "complication of hypotension due to high fluid gain". The same report stated "need restrictions on fluid please!" The resident's record did not reveal any evidence the physician was contacted regarding the blood pressures, complications or recommendations.	F 157	Findings will be reported to the QA Committee for review and further action as needed.		



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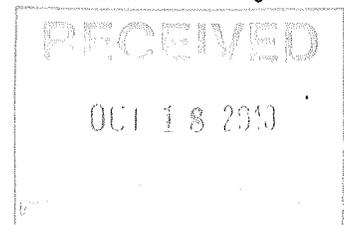
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F 157	Continued From page 4 Observations of the resident's room, on 09/21/10 at 10:35am and 09/22/10 at 3:10pm, revealed the resident had a water pitcher in the room with access to a water faucet in the bathroom. Interview with LPN (Licensed Practical Nurse) #1, on 09/22/10 at 5:00pm, revealed the water pitcher had been removed from the resident's room at this time and the Dialysis request for 1500cc's was clarified with the physician today after surveyor intervention. Interview with LPN #1, on 09/23/10 at 10:45am, revealed when the resident returns to the facility from dialysis, a form is brought to the nurse's station. Whoever is there at the time receives the form, a nurse or CMT (Certified Medication Technician). The sheet is checked, if there is a problem the physician is called, if no problem, it is placed in the chart. The information is provided to the dietary department and the nursing office. The LPN did not know how the two dialysis requests were missed. In addition, the LPN was not aware of the dietary recommendation for the renal diet. The LPN revealed the resident could potentially have fluid overload, high blood pressure, stroke and kidney damage when the physician is not notified of complications and recommendations by the dialysis center or the Registered Dietician. This would include if the fluid restriction is not monitored. Interview with LPN#2 on 09/22/10 at 4:05pm revealed the Dialysis unit sends back a form with weight, vital signs and any fluids or medications received while there. If the form has no concerns it goes on the chart, if it does, the concerns are called to the physician. LPN #2 was not sure if	F 157			

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F 157	Continued From page 5 the information had been called to the physician or not and was not sure if the physician had been made aware of the increased blood pressures, the residents non-compliance with the restriction, or the recommendation for the renal diet.	F 157	Resident #9 was reassessed per policy on 10/23/10 by the interdisciplinary team and referred to therapy for re-assessment. This was done 10/25/10 and therapy continues to recommend the use of the merry walker. The interdisciplinary team met to determine if any reduction of the time in the merry walker was appropriate for the resident. They determined rest periods out of the merry walker in a recliner daily, restorative ambulation with a rolling walker and to be taken out of the merry walker for meals. As per policy resident will be reviewed again in 3 months to see that current care plan remains effective for this resident. The care plan was updated to reflect these changes on 10/25/10. The interdisciplinary team met on 10/25/10 and reviewed the restraints for all residents to determine the appropriateness of the restraint and care plan.		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of twenty-two (22) sampled residents (Resident #9) was free from physical restraints. Resident #9 was placed in a merry walker. The findings include: Review of the facility policy for Restraints, undated, revealed the facility evaluated all devices to determine if the device was a restraint for the specific resident. If a device was determined to be a restraint, the least restrictive device would be used. The facility used a Device Decision Tree to determine how the device would be classified. Observation of Resident #9 on 09/21/10 at 10:25am, 11:00am, 1:10pm, and 2:00pm and on 09/22/10 at 9:00am, and 11:00am, revealed the resident was in a Merry walker wandering around the unit's common areas.	F 221			

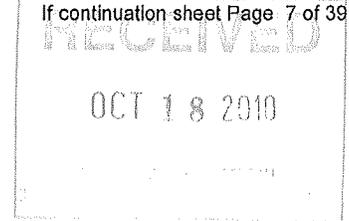
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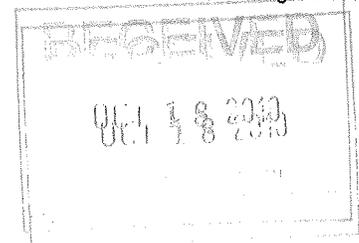
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F 221	Continued From page 6 Review of the clinical record for Resident #9 revealed the resident was admitted on 08/04/10 with diagnoses of Alzheimer's Disease and Dementia with Behaviors. The resident was seen by Physical Therapy on 08/04/10 and was determined to lack the cognitive ability to participate in therapy and required maximum assistance to walk with a rolling walker. The nursing staff had placed the resident in a merry walker to ambulate as this was the same device used at a medical center prior to admission to the facility. Nursing had tried to get the resident to sit in a chair and the resident refused so a merry walker was implemented on 08/04/10. Therapy discharged the resident to restorative nursing on 08/04/10. Review of the Device Decision Tree completed 08/04/10 revealed the merry walker would be a restraint for Resident #9 and the medical symptoms being treated were poor balance and no safety awareness. The resident was not cognitively able to open the merry walker gate to transfer his/her self to bed or a different chair. In addition, the facility identified the resident as being physically aggressive, wandered, and had agitation. Review of the admission MDS assessment completed on 08/11/10 revealed the resident had a severe impairment in the ability to make daily care decision and required limited to extensive assistance for care needs. The Falls Resident Assessment Protocol (RAP) revealed the resident had no history of falls; however, nursing notes from 09/12/10 revealed the resident was found on the floor on his/her knees in the merry walker in the dining room. Nursing notes from 09/20/10 revealed the resident was again found on the floor on his/her knees. The facility failed to	F 221	Care plans were reviewed to ensure they were accurate. Licensed staff were re-educated on the facility policy for restraints on 10/15/10 by the DON. Per policy all devices are assessed as to the effect of the individual resident. If a device is determined to act as a restraint for a resident, a restraint assessment is completed; resident and family are notified of the risk/benefits of restraint usage and the restraint is re-assessed no less than quarterly to ensure that the device is still appropriate and that the least restrictive device is in use and that if appropriate reduction efforts are attempted. All restraint usage is incorporated into the care plan. All restraint reviews will be reviewed by the interdisciplinary team for the next 3 months to determine that the policy is being followed and that measures are taken to ensure the restraint being used is appropriate, that the least restrictive device is in use and that reduction efforts are attempted and documented.		



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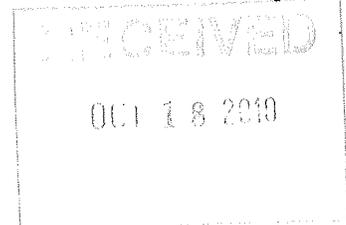
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F 221	Continued From page 7 provide evidence that alternatives were attempted before applying a restraint. Review of the care plan revealed the facility did not address the resident's risk for decline and even though Physical Therapy recommended restorative nursing, the facility did not provide a restorative nursing program to prevent a decline in the resident. In addition, the care plan did not contain a plan to attempt to decrease the amount of time the resident spent unrestrained. Interview with Registered Nurse (RN) #1 on 09/22/10 at 11:45am, revealed Resident #9 had used a merry walker at a medical center prior to admission, so when the resident refused to sit in a chair, the merry walker was applied on the day of admission. She stated no other alternatives were attempted prior to using the restraint and there were currently no plans to decrease the level of the restraint or the amount of time the resident spent restrained. Interview with Certified Nurse Aide (CNA) #2 revealed Resident #9 was restrained in the merry walker all day except during meal time. She stated the resident was not able to release the gate and exit the walker independently.	F 221	Residents #19 and 20 are no longer residents of this facility The charts for residents #1 and 9 were reviewed by the SSD on 10/8/10, She reviewed the nurses notes, physicians progress reports, caretracker documentation and social service and activities notes for the past 30 days for any noted behaviors. She interviewed nursing staff on 10/8/10 regarding any noted behaviors. Based on this information neither resident has exhibited any behaviors in the past 30 days. SSD documented her actions and findings in the medical record. Social Services reviewed all charts for physician orders for Comfort Measures and checked to see that there were careplans in place for each of those residents, SSD then contacted each resident/responsible party to ensure that their wishes were being honored, she then documented the same in the medical record	
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 250		



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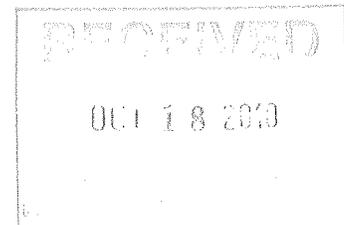
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F 250	Continued From page 8 by: Based on interview and record review, it was determined the facility failed to provide medically-related social services for four (4) of twenty-two (22) sampled residents (Residents #1, #9, #19, and #20) to ensure residents with restraints, behaviors, and Advance Directives received the highest practicable physical, mental, and psychosocial well-being. Resident #1 had behaviors including kicking at another resident and taking antipsychotic medications without interventions from social services. Resident #9 exhibited an altered mood, was aggressive toward another resident, wandered, and could be agitated. There was no evidence social services was involved when these behaviors occurred. Residents #19 and #20 were determined to be terminal and comfort care was ordered by the physicians. There was no evidence to show social services addressed the needs of the terminal residents. The findings include: Interview with the Social Services Designee on 09/23/10 at 2:00pm, revealed the facility did not have policies for Social Services; however, the facility provided a copy of the job description for the Social Services Designee. Review of the Social Services Director/Designee (SSD) Job Description, dated 11/04/07, revealed the SSD was responsible to plan, organize, implement, and evaluate to provide services that meet the social and/or emotional needs that affect the residents' ability to achieve their highest level of function. The essential duties of the SSD included; complete assessments and assist with the plans of care; interpret and communicate the	F 250	Nursing staff will be in-serviced on 10/15/10 by the DON in regards to reporting any resident behavior to the nurse and SSD for appropriate interventions/follow up. Licensed staff will be in-serviced on 10/15/10 by the DON to place behaviors on 24 hour report sheet. Any behavior noted/reported will be reviewed in the morning meeting to ensure communication to SS for any needed intervention. DON will audit 24 hour reports for any reported behaviors for 30 days to ensure the practice is being followed, the corporate Social Service Consultant will audit Social Service notes monthly for 3 months to ensure that appropriate documentation is present regarding social service intervention in behavior management and in ensuring that those residents on Comfort Measures are having their wishes honored. These audits will be reported to the facility QA Committee for review		



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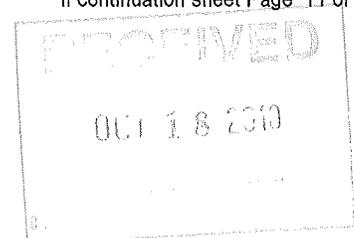
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F 250	<p>Continued From page 9</p> <p>social, psychological and emotional needs of the residents to other team members; identify and seek ways to meet residents' individual needs; provide or arrange counseling to meet residents' needs; complete required documentation in the clinical record; and develop social services programs to meet residents' needs.</p> <p>Review of the clinical record for Resident #1 revealed the resident was admitted with diagnoses of Paralysis Agitans, Dementia, and Dysphagia. The facility completed an annual Minimum Data Set (MDS) assessment on 06/15/10 which indicated the resident had a moderate impairment on the ability to make daily care decisions with both long and short term memory loss. The resident was able to understand verbal communication and was understood when speaking. The resident required extensive assistance with all activities of daily living (ADL). On 08/08/10, the resident was noted to smack another resident who was hanging on to the resident's house coat. On 08/12/10, the resident was noted to be kicking at another resident in the dining room. The resident received an antipsychotic medication. Review of the clinical notes revealed no evidence the SSD addressed the behaviors or documented the efficacy of social services programs implemented to meet the resident's needs.</p> <p>Review of the clinical record for Resident #9 revealed the resident was admitted with diagnoses of Alzheimer's Disease, Dementia with Behaviors, and Epilepsy. The facility completed an admission MDS assessment on 08/11/10 which indicated the resident had a severe impairment in the ability to make daily care decisions. The resident exhibited sad and</p>	F 250			



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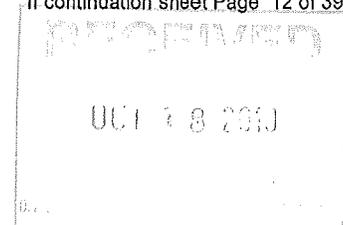
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F 250	<p>Continued From page 10</p> <p>restless behavior and required extensive assistance with ADLs. The resident used a merry walker and received antipsychotic and hypnotic medications.</p> <p>Review of the nursing notes for 08/04/10 revealed the resident was using the merry walker and wandering into other resident's rooms and on 08/08/10 the resident was smacked by another resident after grabbing the other resident's house coat. Throughout the nursing notes there was documentation of the resident wandering all around the nursing unit. Review of the SSD's documentation revealed no evidence the SSD implemented any social service programs to meet the resident's needs.</p> <p>Review of the clinical record for Resident #19 revealed the resident was admitted with diagnoses of Alzheimer's Disease and Congestive Heart Failure. The resident was admitted from an acute care facility where the resident was treated after having an acute cerebral artery infarction on 05/22/10. On 05/25/10, the physician explained to the family that the resident had a guarded prognosis long term. The spouse, health care surrogate, decided to have a gastric tube placed even though the resident had an advanced directive requesting no tube feedings. The facility completed an admission MDS assessment on 06/03/10 which revealed the resident required total care with ADLs and had a severe impairment in the ability to make daily care decisions. On 08/17/10, the physician ordered comfort care. Review of the social service documentation revealed no evidence of any social service programs to meet the resident's needs.</p>	F 250			



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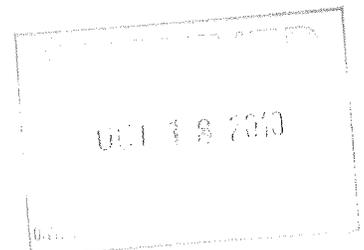
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F 250	<p>Continued From page 11</p> <p>Review of the clinical record for Resident #20 revealed the resident was admitted with diagnoses of End Stage Friedrich's Ataxia and Adult Neglect. The physician noted on 03/09/10 that the family had requested a feeding tube as the resident was not eating well and was losing weight. The quarterly MDS assessment completed on 03/20/10 revealed the resident had behaviors of crying and being inappropriate socially. On 04/18/10, the resident had a gastric tube placed for feeding. On 07/31/10 the physician noted the resident now had excessive pain and was basically receiving comfort care. The facility completed an annual MDS assessment on 08/13/10 which indicated the resident was declining and required total assistance with all ADLs. The only evidence located in the SSD documentation was a note on 08/18/10 that comfort care had been ordered. There was no other evidence the SSD implemented a social services program to meet the resident's needs.</p> <p>Interview with the SSD on 09/23/10 at 2:00pm, revealed she was responsible for the social services in the facility. She stated she did not address resident behaviors in the clinical record. She stated there was a behavior nurse, no longer employed, who managed behaviors in the facility in the past and it had been a long time since she had played that role. She revealed she did not develop social services interventions and did not visit residents one to one to evaluate the effectiveness of the care plan and was not in attendance at care plan meetings as she was not needed. She revealed no involvement with residents that were restrained and she did not follow-up to ensure advanced directives were followed by the facility. She stated she had</p>	F 250			



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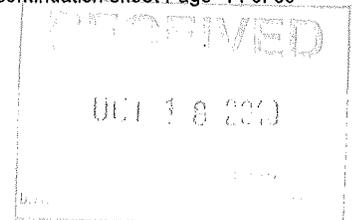
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F 250	Continued From page 12 received training at seminars regarding social services and including behavior management. She stated she did not do anything specifically for residents on comfort care. She indicated she thought she was advocating for the residents; however, she sees she has not. She stated she would be managing admissions in the future.	F 250	Resident #12 had his care plan updated on 9/29/10 to address the monitoring of fluids and the shunt.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop an initial plan of care to address the care and monitoring of a dialysis shunt, fluid restriction, and behaviors for two (2) of twenty-two (22) sampled residents	F 279	The care plan for resident #9 was updated on 10/25/10 for staff to intervene when they saw the resident approaching other residents. Staff will be inserviced on 10/15/10 by DON when they see the resident in the hall they are to try and redirect the resident. All dialysis residents will have their care plans reviewed by 10/25/10 to ensure the care plan includes monitoring of fluids and shunt. A 100% audit will be done by 10/25/10 on resident care plans to ensure any known behavior was (is) addressed and care planned.	10-26-10



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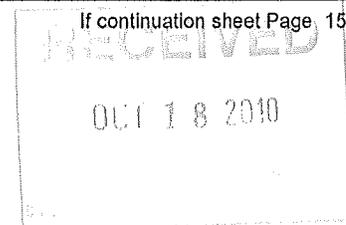
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F 279	Continued From page 13 (Residents #12 and #9). The findings include: 1) Review of the facility's policy provided by the nursing department revealed, Chapter 21, pages 698, 699 and page 702 of the Lippincott Manual, 2001, Seventh Edition, titled RENAL AND URINARY DISORDERS, under the heading Continuous Ambulatory Peritoneal Dialysis; indicated the procedure, requirements, methods, complications and monitoring during Hemodialysis treatments. It also included the lifestyle management for Chronic Hemodialysis: 1. Dietary management involves restriction or adjustment of protein, sodium, potassium, or fluid intake (the renal diet and fluid restriction); 2. Ongoing health care monitoring includes careful adjustment of medications that are normally excreted by the kidney or are dialyzable; 3. Surveillance for complications: Arteriosclerotic Cardiovascular Disease, Congestive Heart Failure, Disturbance of Lipid Metabolism, Coronary Heart Disease, Stroke; Intercurrent infection; Anemia and Fatigue; Gastric ulcers and other problems; Bone problems; Hypertension; and Psychosocial problems (monitoring for complications through interventions on the plan of care). Interview with the Director of Nurses on 09/23/10 at 3:15pm revealed the pages provided from the Lippincott Manual were the nursing department's policy and procedure for the care of the Dialysis patient. Record review for Resident #12 revealed an admission date of 09/16/10 with diagnoses of End Stage Renal Disease, Diabetes, Hypertension,	F 279	Staff will be inserviced on 10/15/10 by DON in regards to reporting any resident behavior the to SSD for appropriate interventions/follow up. Licensed staff will be inserviced 10/15/10 by DON to place behaviors on 24 hour report sheet. Any behavior noted/reported will be reviewed in the morning meeting. Nursing staff were inserviced on 10/15/10 by the DON regarding procedures for monitoring the fluid restrictions and for shunt care for any resident undergoing dialysis. Staff were re-educated on the practice of entering all fluids consumed by the resident into CareTracker for accurate documentation and review. The DON will monitor the 24 hour reports for 30 days to ensure that the procedures are being followed. The fluid intake report (CareTracker) will be monitored by the ADON daily for 30 days to ensure that all fluids are being tracked.	



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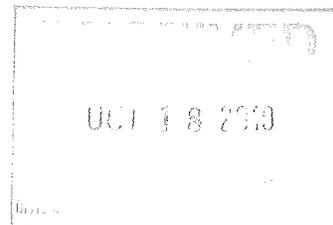
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F 279	<p>Continued From page 14</p> <p>Congestive Heart Failure, Cirrhosis of the Liver, Hypothyroidism, Anxiety, Depression and Insomnia. The admission physician orders dated 09/16/10 indicated the resident was to receive a regular diet with 2000 cc fluid restriction. The initial plan of care dated 09/16/10 indicated the resident was on a regular diet, a fluid restriction of 2000 cc and receiving dialysis 3 days a week on M-W-F. There was no evidence the facility addressed assessment or monitoring the resident's shunt, monitoring the fluid restriction or how dietary and nursing were to provide the 2000cc per day. There were no interventions on the plan of care to direct the staff in how to identify concerns or accomplish any goals pertaining to the outcome of dialysis treatments for the resident i.e. if the resident was to have a water pitcher at bed side.</p> <p>Review of the nursing assistant care plan dated "Sept. 10" indicated the resident was receiving a regular diet; however, there was no evidence the facility had recorded the physician's ordered fluid restriction, no instruction of the amount of fluids the nursing assistants were to provide nor how they were to monitor the resident's fluid intake. The facility revised the plan of care on 09/17/10 detailing the diet was changed to; no added salt and no concentrated sweets; however, there was no evidence of any other changes. In addition, the plan of care did not direct the nursing assistants as to whether the resident could have a water pitcher at bedside or not.</p> <p>Interview with Certified Nurse Aide (CNA) #6, who was assigned to the care of Resident #12, on 09/23/10 at 10:25am revealed the nursing assistant is to total the amount after each meal so the resident does not go over the restricted</p>	F 279	<p>Following our initial reviews we will assign monitoring of the 24 hour report and the fluid intakes to the unit managers to ensure continued compliance.</p> <p>Follow up of monitoring fluid intake and the 24 hour report of resident behaviors will be reviewed by QA Committee</p>	



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F 279	<p>Continued From page 15</p> <p>amount. The resident should not have a water pitcher in their room because they could fill it from the sink and staff would not know the true amount of water taken in. If the nursing assistant fills the pitcher they would look at how much was left. This would not be accurate.</p> <p>Interview with CNA #7, who was assigned to the care of Resident #12, on 09/23/10 at 10:35am revealed they are told in report regarding fluid restrictions. The CNA keeps track of what the resident eats and drinks then records the information in the computer (care tracker). It is reported to the nurse if the resident goes over the restricted amount. Resident #12 does not go over the amount; however, the CNA did not know for certain if the resident is compliant with the restriction or not. If the resident is compliant it would be fine for them to have a water pitcher. If not the resident should not have a water pitcher. The CNA stated Resident #12 is alert and oriented and could say how much he drank. Normally the nurse would tell the nursing assistant if the resident could have a water pitcher; however, the CNA was not sure if the nurse had instructed the staff to place a water pitcher at bedside and had not asked.</p> <p>Review of the September 2010 Medication Administration Record (MAR), Treatment Administration Record (TAR) and nurses notes revealed there was no documented evidence the facility had assessed the shunt. There was no evidence of a shunt assessment form utilized by the facility. The facility provided two days of fluid restriction intake records dated 09/17/10 and 09/19/10 that were partially completed. The intake record printed from the computer revealed the resident exceeded the 2000cc intake on</p>	F 279		



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F 279	Continued From page 16 09/19/10 by 550cc. Refer to F309. Observations of Resident #12 on 09/21/10 at 10:35am and 09/22/10 at 3:10pm revealed a water pitcher sitting on the bed side table that contained water. Interview with the Dietary Manager (DM) on 09/22/10 at 3:55pm revealed the Registered Dietician (RD) comes weekly and has an assessment list waiting for them of residents due. The RD is due next Monday the 27th. The RD would make recommendations at that time for fluid restrictions. The DM does not make recommendations nor enter any information on the initial care plan. Interview with the Minimum Data Set (MDS) nurse on 09/22/10 at 11:20am revealed the unit manager is responsible for ensuring careplans are initiated and updated. Resident's on fluid restriction will have dietary involvement to devise a plan regarding fluid intake and staff responsibility. The MDS nurse was not sure if this had been done as they were not involved with development of the initial plan of care which is the unit manager's responsibility. Interview with Licensed Practical Nurse (LPN) #1, on 09/23/10 at 10:45am, revealed the initial plan of care was developed by the unit manager; however, he/she is not available due to a leave of absence. The initial plan of care should have cc's calculated by dietary so staff would know how much to give and should have instructions on assessing the shunt. Interview with LPN #2 on 09/22/10 at 4:05pm revealed the resident should not have a water	F 279		

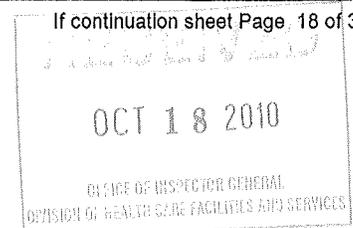
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OFFICE OF INSPECTION GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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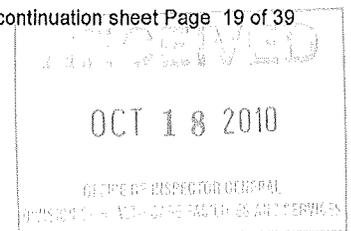
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F 279	<p>Continued From page 17</p> <p>pitcher in the room. The LPN was surprised to hear the resident had a water pitcher at bedside and that it was not on the plan of care. The LPN indicated the intake would not be accurate if the resident could drink water without staff knowledge.</p> <p>2) Observation of Resident #9, on 09/21/10 at 10:25am, 11:00am, and 1:10pm and on 09/22/10 at 9:00am and 11:00am, revealed he/she was up in a merry walker wandering around the unit. The resident was close enough to other residents to have direct contact.</p> <p>Review of the clinical record revealed Resident #9 was admitted to the facility with diagnoses of Alzheimer's Disease and Dementia with Behaviors. Review of the Minimum Data Set (MDS) assessment dated 08/11/10 revealed the facility assessed the resident as having a severe impairment in the ability to make daily care decisions with both short and long term memory loss. In addition the resident was assessed as ambulatory with the use of a merry walker.</p> <p>Review of the Nursing notes dated 08/04/10 revealed the resident was wandering in and out of other residents' rooms and running into residents with the merry walker. Further review revealed on 08/08/10 Resident #9 grabbed another resident by the collar and was smacked, resulting in staff intervention.</p> <p>Review of Resident #9's care plan, dated 08/09/10 and titled: Resident is experiencing behaviors, revealed the staff were to ensure Resident #9 remained an arm's reach from other residents; however, the facility did not detail how staff were to accomplish this task.</p>	F 279			



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F 279	Continued From page 18 Interview with the MDS Nurse on 09/23/10 at 11:20am revealed after review of the resident's care plan, there should have been interventions developed to ensure the staff kept the resident out of arm's reach of other residents to prevent altercations. The MDS nurse, who completed the admission assessment and developed the care plan, was not a part of the interdisciplinary team. The MDS nurse does not meet with the team to discuss the developed care plan to ensure it meets the holistic needs of the resident. She stated the LPN from the units reviewed the care plan and gave instructions for any changes to the MDS nurse. Interview with the Director of Nursing on 09/23/10 at 3:15pm, revealed per company policy, the MDS nurse was not a part of the interdisciplinary care plan team. The care plans are reviewed by the LPN from the units and other members of the team with direction to the MDS nurse for changes. There was no policy provided by the facility.	F 279	Resident #19-20 are no longer in the facility. The charts for resident #1 was reviewed by the SSD on 10/8/10. She reviewed the nurses notes, physicians progress reports, caretracker documentation and social service and activities notes for the past 30 days for any noted behaviors. She interviewed nursing staff on 10/8/10 regarding any noted behaviors. Based on this information this resident has not exhibited any behaviors in the past 30 days. SSD documented her actions and findings in the medical record.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	Resident #15 was educated on the importance of following fluid restrictions on 10/19/10 by SSD. He voiced understanding and this was documented in the medical record. Social Services reviewed all charts for physician orders for Comfort Measures and checked to see that there were careplans in place for each of those residents, SSD then contacted each resident/responsible party to	10-26-10



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F 280	<p>Continued From page 19</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to periodically review and revise the comprehensive care plan for four (4) of twenty-two (22) sampled residents (Resident #1, #15, #19, and #20). Resident #1 had behaviors and changes in eating that were not care planned. Residents #19 and #20 were determined to be receiving comfort care only; however, the care plans were not revised to include interventions for social services programs. Resident #15 was to receive education on dietary and fluid restrictions. However, there was no documented evidence the resident was educated.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing on 09/23/10 at 10:00am, revealed the facility utilized the Resident Assessment Instrument (RAI) 2.0 Manual for care planning.</p> <p>Review of the clinical record for Resident #19 revealed the resident was admitted to the facility with diagnoses of Cerebral Vascular Accident, Alzheimer's Disease and Dementia. The facility completed an admission Minimum Data Set</p>	F 280	<p>ensure that their wishes were being honored, she then documented the same in the medical record.</p> <p>Nursing staff will be in-serviced on 10/15/10 by the DON in regards to reporting any resident behavior to the nurse and SSD for appropriate interventions/follow up. Licensed staff will be in-serviced on 10/15/10 by the DON to place behaviors on 24 hour report sheet. Any behavior noted/reported will be reviewed in the morning meeting to ensure communication to SS for any needed intervention.</p> <p>DON will audit 24 hour reports for any reported behaviors for 30 days to ensure the practice is being followed, the corporate Social Service Consultant will audit Social Service notes monthly for 3 months to ensure that appropriate documentation is present regarding social service intervention in behavior management and in ensuring that</p>	

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2010
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
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F 280	<p>Continued From page 20</p> <p>(MDS) assessment on 06/03/10 which revealed the resident was severely impaired in the ability to make daily care decisions. The resident required a tube feeding for nutrition, received oxygen, had an indwelling catheter, and required total care for all care needs. The resident had an Advanced Directive in place which specified no tube feeding if an incurable disease or irreversible condition existed. Review of the physician notes from the hospital stay revealed the spouse requested the feeding tube be placed and so it was. The resident continued to decline and on 07/06/10 the physician wrote an order to not replace the feeding tube if it came out. On 07/24/10 the physician ordered an injectable narcotic for comfort and intravenous fluids until the family made a decision on whether they wanted the tube feeding stopped. The tube feeding continued and on 08/17/10 the physician ordered comfort care only. Review of the care plan revealed the facility failed to revise the care plan to meet the resident's changing needs for social services until 08/18/10. The resident expired on 09/06/10.</p> <p>Review of the clinical record for Resident #20 revealed the resident was admitted with diagnoses of End Stage Friedrich's Ataxia and Adult Neglect. The facility completed an annual MDS assessment on 08/13/10 which revealed the resident had a severe impairment in the ability to make daily care decisions. The resident required total care with all needs. On 03/09/10, the dietician noted the resident was losing weight and may need a feeding tube, and on the same day, the physician noted the son had requested a feeding tube be placed. On 08/18/10 the physician wrote an order for comfort measures only and social services documented the resident was declining and was to have comfort measures</p>	F 280		

