

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

PRINTED: 01/23/2013
FORM APPROVED
OMB NO. 0938-0391

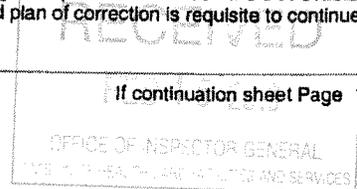
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185190	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER BAPTIST HOSPITAL NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 NEW MOODY LANE LA GRANGE, KY 40031
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F 000	INITIAL COMMENTS A recertification health survey was initiated on 01/08/13 and concluded on 01/10/13 with a Life Safety Code survey conducted and concluded on 01/09/13. Deficiencies were cited at the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
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 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. This REQUIREMENT is not met as evidenced by:	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Maisha N. Buren* TITLE: *Cell menu operator* (X6) DATE: *2-15-13*

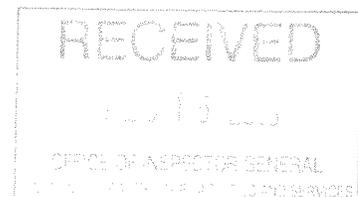
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 280	<p>Continued From page 1</p> <p>Based on observation, interview, record review and facility policy review, it was determined the facility failed to review and revise the comprehensive care plan for three (3) of eight (8) sampled residents and two (2) unsampled residents, Residents #3, #5, and #7. The facility did not review or revise the comprehensive care plans regarding oxygen therapy for Residents #3 and #5. The facility did not review or revise the comprehensive care plan for Resident #7 regarding post fall interventions.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Assessment/Reassessment (dated 7/12) revealed assessments included the collection and analysis of relevant physiological data regarding each patient. This process was utilized to determine whether the patient's care needs and/or the plan of care required revision based on reassessment.</p> <p>Observation of Resident #3, on 01/08/13 at 11:45 AM, 3:30 PM and 4:30 PM, revealed the resident did not have oxygen on. Further observation of Resident #3, on 01/09/12 at 8:30 AM, 2:00 PM, and 3:00 PM, revealed the resident had no oxygen on.</p> <p>Review of the clinical record revealed the facility admitted the resident on 01/26/11 with diagnoses of Alzheimer's Dementia and Chronic Obstructive Pulmonary Disease (COPD). Review of the physician orders for Resident #3 revealed an order dated 06/25/12 for oxygen therapy at two (2) liters per nasal cannula to be delivered continuously. Review of Resident #3's</p>	F 280	<ol style="list-style-type: none"> Resident #3 – MD order received to discontinue continuous O2 and give O2 2L/NC @ night and prn O2 saturations <88% or symptomatic. The care plan was updated immediately. Resident #5 – MD order received to change O2 to 2L/NC prn to keep O2 saturations ≤ 92%. The care plan was updated immediately. Resident #7 – care plan changed to reflect more frequent monitoring and comfort checks, including toileting, positioning and fluid/snacks. All residents on oxygen were audited for appropriate orders and observed for accurate oxygen therapy. One resident had orders for night-time oxygen only. MD was called and order was changed to include a prn order for oxygen saturations < 90%. The Care Plan was updated. No residents were at risk because O2 saturations are assessed on all residents at least every shift, more frequently if indicated. Physicians are notified if indicated by assessment. All residents have a falls risk assessment done every shift with implementation of falls protocol for those at high risk. All with high-risk designation had appropriate interventions and signage in place per falls protocol. 	2/4/13



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F 280	<p>Continued From page 2</p> <p>comprehensive care plan revealed he/she was to have oxygen administration at nighttime only with no indication of revision of the plan for continuous oxygen administration.</p> <p>Interview with Resident #3, on 01/08/13 at 4:40 PM, revealed he/she did not have oxygen on all the time and was unaware if the doctor wanted it to be worn continuously. Resident #3 stated the nursing staff would take the oxygen off in the mornings and reapply it at night.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 01/10/13 at 9:45 AM, revealed it was her understanding Resident #3 was to have oxygen on at nighttime only. She stated she got this information from the off-going CNA when she reported to duty, but it was not written on the board in the nursing break room where information about the residents' was documented.</p> <p>Interview with RN #4, on 01/10/13 at 2:50 PM, revealed it was her understanding Resident #3 was to have oxygen on at nighttime only and she had gotten this information from the nurse who gave her report. She stated she had not referred to the comprehensive care plan for Resident #3 but relied on the other nurses to give her correct information. RN #4 stated it was her understanding the MDS nurses would review and revise a comprehensive care plan to include new or different physician orders and she would inform the CNA's verbally, if there were changes for any resident.</p> <p>Interview with MDS Nurse #4, on 01/10/13 at 2:30 PM, revealed any nurse could review and revise a resident's comprehensive care plan based on a</p>	F 280	<p>3. Mandatory In-services held on January 29 and 30. Attachment A</p> <p>Falls: Falls Protocol educated to all Staff including:</p> <ul style="list-style-type: none"> • components and completion of the Post-Fall order set • Updating of the care plan <p>A checklist was developed and attached to the Falls Protocol to be completed by the nurse. The checklist includes:</p> <ul style="list-style-type: none"> • Each step of Falls Protocol • Care plan updates. • The checklist is to be signed and dated by the nurse and turned into the DON when completed. <p>Attachment B</p>	
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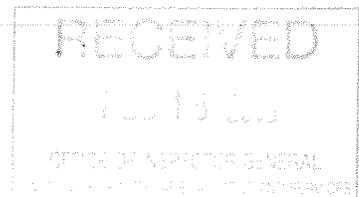
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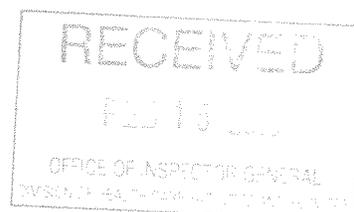
F 280	<p>Continued From page 3</p> <p>reassessment of the resident, but sometimes the nurses did rely on the MDS nurses to review and revise the care plans.</p> <p>Interview with the Director of Nursing (DON), on 01/10/13 at 4:10 PM, revealed it was the duty of all nurses to review and revise the residents' plans of care as needed. She stated the information passed on in the nursing report should be the information contained in the comprehensive plan of care and current physician orders. The DON stated her nursing department had a communication problem.</p> <p>2. Review of Resident #5's medical record revealed the facility admitted the resident on 03/05/12 with the following diagnoses: Chronic Obstructive Pulmonary Disease; Upper Respiratory Infection; Anxiety; and High Blood Pressure. The initial Minimum Data Set, dated 03/20/12, revealed the resident had a brief interview of mental status score of 15 indicating intact cognition and the use of oxygen therapy. Admission orders, dated 03/08/12, revealed an order for humidified oxygen at a flow rate of 2 liter per minute.</p> <p>Observations of Resident #5, on 01/08/13 at 11:12 AM, 2:00 PM, 2:15 PM, and 4:00 PM, and 01/09/13 at 8:20 AM, revealed the resident was not wearing oxygen, nor was there an oxygen setup in the room.</p> <p>Interview with Resident #5, on 01/09/13 at 4:30 PM, revealed the resident was on oxygen the first 6 weeks after admission. The resident revealed having a long history of lung problems and experiencing shortness of air in the mornings</p>	F 280	<p>Oxygen:</p> <p>The in-service also included education re:</p> <ul style="list-style-type: none"> • Oxygen orders and • Necessity of updating O2 orders as resident condition changes. • Developed list of all residents on Oxygen and current orders. List to be kept at desk and updated when new orders and/or new patients admitted. • It is to be checked for accuracy every 24 hours when completing chart checks. <p>Attachment C</p> <p>Care Plans:</p> <p>The previous process to update care plans was for nurses to notify MDS Coordinator of changes and she would update. Nurses have now been instructed to update the care plan themselves whenever new orders received or resident has change in condition.</p>	
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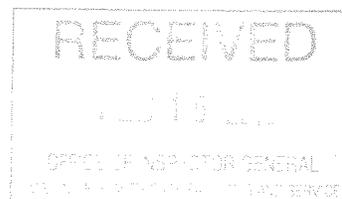
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F 280	<p>Continued From page 4 when trying to get dressed.</p> <p>Review of the resident's comprehensive plan of care revealed the care plan was not revised to include use of oxygen therapy. The care plan listed a problem of infection risk secondary to chronic progressive disease; however, neither oxygen therapy nor the resident's reported problem of shortness of air with morning activity were addressed on the care planned.</p> <p>Interview with Registered Nurse (RN) #3, on 01/10/12 at 3:00 PM, revealed the resident was on oxygen when first admitted but the facility discontinued the oxygen due to cost concerns. The RN revealed she was aware of the resident being short of air in the morning, and had discussed it with the resident who agreed to call for assistance if he/she wanted the oxygen. The RN revealed she was not aware of how the physicians order directed the use of the oxygen or how it was care planned. The RN revealed the care plan was used to make sure the facility was doing what was needed to meet the patients needs. The RN revealed it was important to utilize and follow the plan of care.</p> <p>Interview with the MDS coordinator, on 01/10/13 at 4:50 PM, revealed she generally utilized the resident's diagnosis and their MDS triggers to revise the plan of care. The MD'S Coordinator revealed she was not aware of the physician's order for oxygen usage, but felt monitoring medication under risk for infection should have covered the residents needs for interventions related to oxygen therapy.</p> <p>3. Review of Resident #7's medical record</p>	F 280	<p>3. Communication:</p> <p>To ensure transmittal of accurate resident information, a new CNA Report Sheet was developed and instruction for use completed during the in-service. The report sheet will be done in pencil and updated as resident condition warrants or orders change. The unit secretary and/or nurses will be responsible for updating the report. The aides will utilize this document during shift report.</p> <p>Attachment D</p> <p>In addition, the nurses computerized Daily Report/Work sheet now includes oxygen orders and will be updated as new orders or resident condition warrants by the nurses or unit secretary.</p> <p>Attachment E</p> <p>ADDENDUM TO #3 Instructors of the in-service were the DON and MDS Coordinator. The staff included all RN's, LPN's, CNA's, Activity Director, Assistant Activity Director and Unit Secretary. The in-service covered Falls Protocol, Oxygen orders, care plans and following MD orders. 100% of staff were in-serviced.</p> <p>Attachment A1 Staff competency post-training was determined through demonstration and teach-back of information covered during the in-service.</p> <p>Attachment F</p>		



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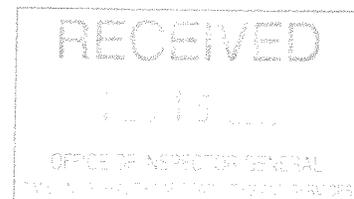
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F 280	<p>Continued From page 5</p> <p>revealed the facility admitted the resident on 10/09/12 with the following diagnoses: Leukemia; Chronic Obstructive Pulmonary Disease; Hypertension; and Congestive Heart Failure. The record revealed the resident fell on 11/17/12 and was found lying on the bathroom floor. Review of Resident #7's care plan revealed an intervention to reinforce bed and chair alarm. Review of the Minimum Data Set, 10/21/12, revealed a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact.</p> <p>Observation of Resident #7, on 01/10/13 at 2:30 PM, revealed the resident was sitting in a recliner next to the bed reading an electronic book. The call light was draped over the arm of the chair and a yellow falls band was noted sitting on the bedside table. Interview with the resident at that time revealed he/she did not remember falling in the facility. The resident revealed he/she refused the bed and chair alarm and felt he/she was still capable of doing things for himself/herself.</p> <p>Interview with Registered Nurse (RN) #2, on 01/10/13 at 11:30 AM, revealed the resident was alert and oriented and had refused a bed and chair alarm prior to the fall on 11/17/12. The RN revealed she did not know what other nurses or shift were doing to prevent falls, but she had decided to increase safety rounds and leave the resident's door open at night.</p> <p>Review of the resident's plan of care revealed an intervention to reinforce bed and chair alarm dated 11/17/12. No other interventions were noted at that time. Further review revealed the resident fell again the night of 11/22/12 resulting in a hematoma to the forehead.</p>	F 280	<p>ADDENDUM TO #3 cont'd:</p> <p>3. Continued competency and compliance for Falls and Post-Fall Protocol will be accomplished by the DON auditing the Falls Checklist items for documentation completion and accuracy, with immediate follow-up with the nurse when not in compliance. Continued competency for oxygen will be determined by direct observation of resident by the DON or MDS Coordinator for accurate O2 set-up, audit of O2 list weekly.</p> <p>Attachment G & H</p> <p>4. The Post-Fall checklist is to be turned in to the DON after completion. The DON will audit the nursing documentation for all interventions listed, including the care plan update. This will be done with 100% of falls.</p> <p>The listing of residents on oxygen will be kept at the desk and updated by the resident's nurse daily. The DON or MDS Coordinator will audit 100% of the residents on oxygen to verify MD order, Care Plan, and will visually verify that the resident has the appropriate oxygen in place. This will be done weekly.</p> <p>Attachment H</p> <p>The results will be reported to the Evidence Based Care Committee monthly for 3 months and quarterly thereafter, if required.</p>	



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F 280	Continued From page 6 Interview with the MDS Coordinator, on 01/10/13 at 4:50 PM, revealed she was responsible for adding the interventions to the care plan. The MDS Coordinator revealed she inserted interventions based on what she was told by the nurses or by reviewing the resident's chart. The MDS Coordinator revealed she did not remember why the only intervention added after the fall on 11/17/12 was to reinforce a bed alarm that had already been refused. The MDS Coordinator revealed there was currently no system in place to receive communication from the falls committee regarding interventions for falls and she did not remember if she had seen the post fall huddle sheet. Interview with the DON, on 01/10/13 at 10:54 AM, revealed Resident #7 was alert and oriented. The DON revealed the resident did fall on the night of 11/17/12. When asked what was determined to be causal factors and root cause, the DON revealed a root cause analysis was not usually done on falls and was not sure what interventions had been added to prevent further falls. Further interview, on 01/10/13 at 4:15 PM, revealed an intervention to check the resident more frequently was discussed on the huddle form after the fall on 11/17/12, but was never added to the care plan. The DON revealed the MDS coordinator was responsible to update the care plan; however, the MDS coordinator was not made aware of items discussed on post huddle form. The DON revealed reinforcing the bed alarm was not an appropriate intervention for resident #7 after the first fall, and she should have checked the care plans to ensure they were updated appropriately. The DON revealed there	F 280	ADDENDUM TO #4 The monitor results of care planning and physician oxygen orders will be reported by the Skilled Rehab's DON to the Evidence Based Committee (EBC) monthly to ensure 100% compliance for 3 consecutive months and then quarterly for 2013. The compliance with the Falls Protocol is the PI project for the skilled unit for 2013 and will be reported to the EBC for the entire year. The goal is 100% compliance. The same monitor results will be reported quarterly to the Rehab and Skilled Care unit's Quality Assurance/Performance Improvement (QAPI) Committee. The Evidence Based Committee (EBC) is the quality improvement/assurance committee for the facility. The EBC committee is comprised of all disciplines, including lab, radiology, therapies, quality/risk management, case management, acute care, intensive care, environmental services, clinical informatics and administration. The Rehab and Skilled Care unit's Medical Director is the Chair of the EBC and its administrator is a sitting member. The EBC will assess and monitor results and may make recommendations to implement changes or revisions to the processes when compliance is not 100%. In addition, results will be reported by the DON to the Rehab and Skilled Care Unit's QAPI Committee quarterly. This committee is comprised of the DON, MDS Coordinator, Activity Director/Social Service Designee, staff CNA, Staff LPN and RN, Nursing Home Administrator and Medical Director. The committee may make recommendations to implement changes or revisions to the processes as needed.	



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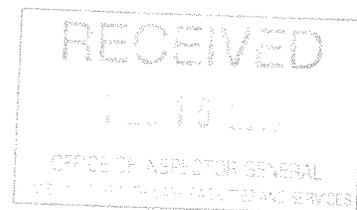
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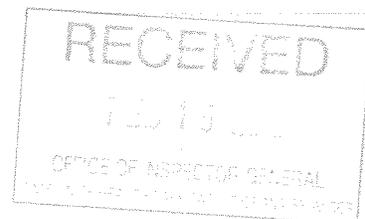
F 280	Continued From page 7	F 280		
F 282	was a problem with communication.	F 282		
SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN			
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy and procedure, it was determined the facility failed to follow the Comprehensive Plan of Care for interventions to prevent falls for one (1) of eight (8) sampled residents and two (2) unsampled residents. (Resident #4).		1. The spouse of Resident #4 was immediately asked not to assist with transfers. All CNA's were instructed by the Director of Nursing not to allow any family to assist with resident transfers unless care planned as a discharge need with appropriate teaching.	2/6/13
	The finding include: Review of the facility's policy regarding Assessment/Reassessment, revised 07/2012, revealed a purpose to provide the best care and treatment possible, taking into consideration the resident's physiological, psychological, social/environmental situation and needs. In order to achieve this goal, the following processes are performed: (1) data would be collected to assess the needs of the patient, (2) data was analyzed to create the information necessary to decide the approach to meet care or treatment needs, and (3) decisions were made regarding patient care or treatment based on the analysis of the information. The MDS		<u>ADDENDUM TO #1</u> The spouse of Resident #4 was immediately asked by the DON on 1/11/13 not to assist with transfers. All CNA's RN's and LPN's were instructed by the Director of Nursing not to allow any family to assist with resident transfers unless care planned as a discharge need with appropriate teaching. This was done on 1/11/13, 1/12/13, 1/13/13 and 1/14/13 and reiterated in the Mandatory in-services held 1/29 & 1/30.	



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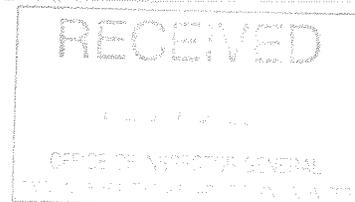
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F 282	<p>Continued From page 8</p> <p>Coordinator was responsible for completion of the comprehensive Plan of Care. Changes or additions to the Plan of Care must be dated and may be performed by any nurse. The MDS Coordinator, with input from the staff nurse was ultimately responsible for updating and maintaining the Plan of Care.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 05/30/12 with the following diagnoses: Subdural Hemorrhage post fall; Hypertension; Dementia; and Parkinsonism. The record revealed the resident had fallen from the mechanical lift sling during transfer, on 11/19/12, resulting in a laceration (cut) on the head requiring staples for closure. To prevent further falls, the facility added the use of the criss cross mechanical lift sling or use two (2) people with the mechanical lift during transfers.</p> <p>Observation of Resident #4, on 01/09/13 at 10:30 AM, revealed Registered Nurse (RN) #1 and Certified Nursing Assistant (CNA #2) used a mechanical lift with a scoop type sling to transfer the resident from the bed to the reclining chair. RN #1 held onto the residents legs during the transfer.</p> <p>Interview with CNA #2, on 01/09/13 at 10:35 AM, revealed she was transferring the resident with the mechanical lift on 11/19/12 when the resident fell. The CNA revealed she was using the manual lift with a scoop type sling, was mid transfer between the chair and the bed, when the resident stiffened his/her body and slid out of the sling onto the floor. The CNA revealed the resident was usually in the mechanical lift four times a day for transfers and had never had a</p>	F 282	<p>2. No other residents have assist from family members or friends.</p> <p><u>ADDENDUM TO #2</u></p> <p>A list of all resident's care planned as requiring lift transfers was obtained from the MDS Coordinator. List was verified with the CNA's. There are five (5) residents being transferred with the sling lift. None of the 5 has received assist from family members or friends per observation and report from CNA's. None of the 5 has fallen or had any injuries since admission related to the lift.</p> <p>3. Mandatory in-service held on January 29 and 30. Staff instructed not to use families/friends as assistants for transfer or equipment needs. Attachment A</p> <p><u>ADDENDUM TO #3</u></p> <p>Mandatory in-service held on January 29 and 30 by the DON and MDS Coordinator. Staff included all RN's, LPN's, CNA's Activity Director, Assistant Activity Director and Unit Secretary. Staff instructed and trained not to use families/friends as assistants for transfer or equipment needs. MDS Coordinator taught nurses how and when to consult the care plan for specifics of care as well as how and when to make changes to the care plan. Competency of staff was determined by demonstration and teach-back of each subject taught. Attachment F</p>	



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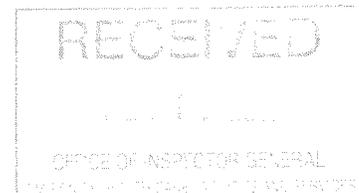
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F 282	<p>Continued From page 9</p> <p>problem before. The CNA revealed she was told what changes were made to the care plan during report the next time she reported to work. The CNA revealed resident information was on the marker board in the break room which was updated by the CNA's.</p> <p>Observation of the marker board in the employee breakroom, on 01/09/13 at 10:35 AM, revealed Resident #4 was to be transferred with the mechanical lift with two (2) person assist.</p> <p>Interview with the Director of Nursing (DON), on 01/09/13 at 12:05 PM, revealed use of the criss cross sling or the use of two (2) people for transfer was added to the care plan for Resident #4. The DON revealed Resident #4's spouse was being utilized as the second person during transfers.</p> <p>Interview with Resident #4's spouse, on 01/10/13 at 1:54 PM, revealed he had assisted the staff with the mechanical lift. The spouse revealed having assisted with positioning, connecting the sling to the lift chair, and walking with the resident during the actual transfer. The spouse revealed the facility did not always utilize 2 staff when using the regular sling and he would be used as the second person assisting with the transfer.</p> <p>Interview with CNA #1, on 01/10/13 at 2:20 PM, revealed they were supposed to use two people for transfers.</p> <p>Interview with Registered Nurse (RN) #3, on 01/10/13 at 3:00 PM, revealed the purpose of the care plan was to ensure staff were doing what was needed to meet resident needs, and a</p>	F 282	<p>4. Director of Nursing or Activity Director will perform direct observation during resident mechanical lift transfers to verify compliance.</p> <p>This will be done weekly on all lift transfer residents and reported to the Evidence Based Care Committee monthly. Expectation will be 100% compliance.</p> <p>ADDENDUM TO #4</p> <p>The Director of Nursing or Activity Assistant will perform at least five (5) observations per week of resident transfers using the mechanical lift. Results will be detailed on an audit sheet. Any deviation from the care plan will result in immediate counseling, with progressive discipline for repeated infractions. The DON will report monitor results to the Evidence Based Committee (EBC) monthly to ensure 100% compliance for 3 consecutive months. The EBC is the quality improvement/assurance committee for the facility. The EBC committee is comprised of all disciplines, including lab, radiology, therapies, quality/risk management, case management, acute care, intensive care, environmental services, clinical informatics and administration. The Rehab and Skilled Care unit's Medical Director is the Chair of the EBC and its administrator is a sitting member. The EBC will assess and monitor results and may make recommendations to implement changes or revisions to the processes when compliance is not 100%. In addition, results will be reported by the DON to the Rehab and Skilled Care Unit's QAPI Committee quarterly. This</p>	



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F 282	Continued From page 10 potential to not meet the set goal if not utilized. The RN revealed she was the nurse on duty the day of the fall, and decided during the post fall huddle to use the criss cross sling or to use two (2) people for transfers. The RN revealed she was aware the resident's spouse was being used as the second person for transfers and revealed the spouse did not have training on the use of the mechanical lift. The RN revealed she felt it was appropriate to use the resident's spouse as it was long term care and more family oriented. The RN revealed the spouse was used more to help calm the resident during the transfer. Interview with the DON, on 01/10/13 at 4:15 PM, revealed the spouse probably should not have been used as the second person for transfers because it was the facility's responsibility to ensure the resident was transferred safely. The DON revealed she had discussed the idea of using the spouse with the MDS Coordinator, the Social Service Director/Activities Director and CNA #1, but did not discuss this with the Risk Manager and the Patient Safety Director. The DON revealed it had not occurred to her that utilizing the spouse could be unsafe for both the resident and the spouse. The DON revealed she was ultimately responsible for ensuring care plans were followed and that residents were transferred with the appropriate supervision to prevent falls.	F 282	<u>ADDENDUM TO #4 CONT'D:</u> committee is comprised of the DON, MDS Coordinator, Activity Director/Social Service Designee, staff CNA, Staff LPN and RN, Nursing Home Administrator and Medical Director. The committee may make recommendations to implement changes or revisions to the processes as needed. Attachment I		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309			



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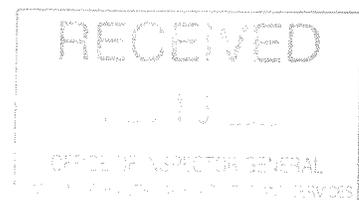
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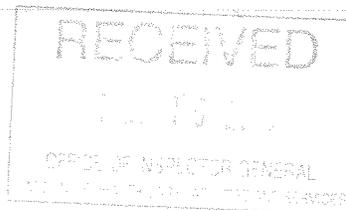
F 309	<p>Continued From page 11 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure physician's orders were followed for three (3) of eight (8) sampled residents and two (2) unsampled residents. Resident #1, Resident #3 and Resident #5. The facility did not follow oxygen therapy orders for Resident #1, #3 and #5.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 01/10/13 at 4:10 PM revealed it was the facility standard of practice to follow physician orders accurately.</p> <p>Observation of Resident #1 on 01/08/13 at 8:40 AM, 11:30 AM, and 4:00 PM, revealed oxygen on the resident at two (2) liters per minute per nasal cannula. In addition, observation of Resident #1 on 01/09/13 at 9:00 AM and 9:30 AM revealed oxygen on the resident at two (2) liters per minute per nasal cannula.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 12/27/12 with diagnoses of Severe Rheumatoid Arthritis and COPD. Review of the physician orders, dated 12/27/12, for Resident #1 revealed the resident was to have oxygen administered at</p>	F 309	<ol style="list-style-type: none"> Resident #1 had orders for O2 2L/NC at night. Physician order received to continue at night and prn O2 saturations <90%. Care plan was updated that day. New orders were placed on the Treatment Administration Record (TAR) to be signed daily by nurses. Resident #3 – MD order received to discontinue continuous O2 and give O2 2L/NC @ night and prn O2 saturations <88% or symptomatic. The care plan was updated immediately. The Treatment Administration Record was revised to reflect new orders to be signed by nurses daily. Resident #5 – MD order received to change O2 to 2L/NC prn to keep O2 saturations ≥ 92%. The care plan was updated immediately. The resident's Treatment Administration Record was revised and nurses will sign daily. All residents charts were audited for appropriate oxygen orders and those with orders were visually observed to verify accurate oxygen therapy. All were found to be correct. No residents were at risk because O2 saturations are routinely assessed on all residents at least every shift, more frequently if indicated. Physicians are notified and interventions implemented if indicated by assessment. 	2/6/13
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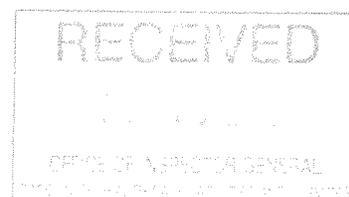
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F 309	<p>Continued From page 12</p> <p>two (2) liters per minute per nasal cannula at HS (nighttime).</p> <p>Observation of Resident #3, on 01/08/13 at 11:45 AM, 3:30 PM and 4:30 PM, revealed the resident did not have oxygen on. Further observation of Resident #3, on 01/09/12 at 8:30 AM, 2:00 PM and 3:00 PM, revealed the resident had no oxygen on.</p> <p>Review of the clinical record revealed the facility admitted the resident on 01/26/11 with diagnoses of Alzheimer's Dementia and Chronic Obstructive Pulmonary Disease (COPD). Review of physician orders for Resident #3 revealed an order, dated 06/25/12, for oxygen therapy at two (2) liters per nasal cannula to be delivered continuously.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 01/08/13 at 3:10 PM, revealed she received report from the off-going CNA every time she reported to duty. She stated it was her understanding Resident #3 wore oxygen at nighttime only and Resident #1 was to wear oxygen continuously. CNA #1 further stated she had no assignment sheet but relied on a board in the nursing break room which had information about the residents on it. She stated the CNA's put the information on the board and there was nothing on the board about Resident #1 or Resident #3 needing oxygen therapy.</p> <p>Interview with CNA #3, on 01/10/13 at 9:45 AM, revealed it was her understanding Resident #1 was to have oxygen on at all times and Resident #3 was to have oxygen on at nighttime. She stated she got this information from the off-going</p>	F 309	<p>3. Mandatory in-services held for all staff which included:</p> <p>Oxygen: The in-service included education re:</p> <ul style="list-style-type: none"> • Oxygen orders • Necessity of updating O2 orders as resident condition changes. • Developed list of all residents on Oxygen and current orders. List to be kept at desk and updated when new orders and/or new patients admitted. • It is to be checked for accuracy every 24 hours when completing chart checks. <p>Attachment C</p> <p>Care Plans:</p> <p>The previous process to update care plans was for nurses to notify MDS Coordinator of changes and she would update. Nurses have now been instructed to update the care plan themselves whenever new orders received or resident has change in condition.</p>	



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F 309	<p>Continued From page 13</p> <p>CNA when she reported to duty, but it was not written on the board in the nursing break room.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/08/13 at 4:00 PM, revealed she thought Resident #1 was to wear oxygen continuously and Resident #3 was to wear oxygen at nighttime only. LPN #1 stated she was afraid the nursing staff had become complacent because the residents' were long-term care. She further stated it was her professional duty to follow physician orders accurately.</p> <p>Interview with Physician #7, on 01/09/13 at 11:30 AM, revealed it would not be very good for a residents health and well-being if an oxygen therapy order was not followed correctly.</p> <p>Interview with RN #4, on 01/10/13 at 2:50 PM, revealed it was her understanding Resident #1 was to have oxygen on continuously and Resident #3 was to have oxygen on at nighttime only. She stated she was surprised the physician orders were for Resident #1 to have oxygen at nighttime and for Resident #3 to have oxygen on continuously. She further stated she relied on the information she got in report from the off-going nurse and she had not reviewed the physician orders to see if that information was correct, but it was her duty to follow physician orders accurately. RN #4 also stated she relied on the night nurses to check the physician orders for accuracy.</p> <p>Continued interview with the Director of Nursing (DON) on 01/10/13 at 4:10 PM revealed the correct oxygen requirements for Resident #1 and Resident #3 should have been passed on in the</p>	F 309	<p>Communication:</p> <p>To ensure transmittal of accurate resident information, a new CNA Report Sheet was developed and instruction for use completed during the in-service. The report sheet will be done in pencil and updated as resident condition warrants or orders change. The unit secretary and/or nurses will be responsible for updating the report. Aides will utilize this document during shift report.</p> <p>The aides were instructed to always consult with the resident's nurse before removing Oxygen.</p> <p>Attachment D</p> <p>In addition, the nurses computerized Daily Report/Work sheet now includes oxygen orders and will be updated as new orders or resident condition warrants by the resident's nurse or unit secretary.</p> <p>Attachment E</p>		



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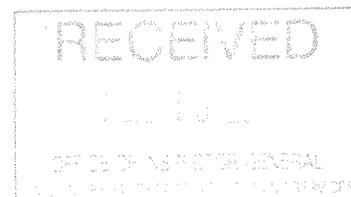
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F 309	<p>Continued From page 14</p> <p>nursing reports and documented on the information board in the nursing break room. The DON stated it was the responsibility of the night nursing staff to review physician orders, to document updated or changed information and to pass that information on in the nursing report. She indicated her nursing department had a communication problem.</p> <p>Review of Resident #5's clinical record revealed the facility admitted the resident on 03/05/12 with the following diagnoses: Chronic Obstructive Pulmonary Disease; Upper Respiratory Infection; Anxiety; and High Blood Pressure. The initial Minimum Data Set (MDS), dated 03/20/12, revealed the resident had a brief interview of mental status score of 15 indicating intact cognition and the use of oxygen therapy. Review of the admission orders, dated 03/08/12, revealed an order for humidified oxygen at a flow rate of 2 liter per minute continuously.</p> <p>Observation of Resident #5, on 01/08/13 at 11:12 AM, 12:00 PM, 2:15 PM, and 4:00 PM, and 01/09/13 at 8:20 AM, revealed the resident was not wearing oxygen, nor was there an oxygen setup in the room.</p> <p>Interview with Resident #5, on 01/09/13 at 4:30 PM, revealed the resident was on oxygen the first 6 weeks after admission. Resident #5 revealed he/she had a long history of lung problems and had experienced shortness of air in the mornings when trying to get dressed. Review of the</p>	F 309	<p>ADDENDUM TO #3</p> <p>Mandatory in-services held on January 29 and 30 by the DON and MDS Coordinator. Staff included all RN's, LPN's, CNA's Activity Director, Assistant Activity Director and Unit Secretary. Nurses were told and trained to contact MD if resident condition changes to obtain new orders, then document changes on Treatment Administration Record (TAR), Care Plan and Aide Report Sheet. Nurses were also instructed and trained to make aides aware of changes immediately. Staff competency post-training was determined on January 29 & 30th through demonstration and teach-back of information covered during the in-service.</p> <p>Attachment A</p> <p>4. The listing of residents on oxygen will be kept at the desk and updated by the resident's nurse daily. The DON or MDS Coordinator will audit to verify MD order, Care Plan and will check that the resident has the appropriate oxygen in place.</p> <p>This audit will also include checking accuracy of CNA Report Sheet and Computerized Nurses Report Sheet.</p> <p>Attachment G</p>	
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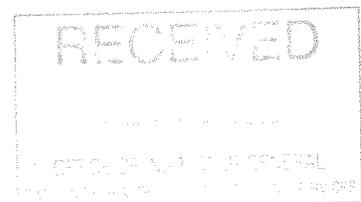
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F 309	<p>Continued From page 15</p> <p>Treatment Administration Record revealed documentation of oxygen administered to Resident #5 in December, 2012 with nothing documented since that time.</p> <p>Interview with Registered Nurse (RN) #3, on 01/10/12 at 3:00 PM, revealed Resident #5 was on oxygen when first admitted. RN #3 revealed the resident was private pay and the oxygen cost one hundred (\$100) dollars a day so the facility tried different interventions to get the resident off the oxygen. RN #3 stated Resident #5 was ill last month and was placed back on the oxygen, but it was removed again on 01/07/13. RN #3 stated she was aware of the resident being short of air in the morning, and had discussed it with the resident who agreed to call for assistance if he/she wanted the oxygen. RN #3 said she was not aware of how the physician's order directed the use of the oxygen.</p> <p>Interview with Resident #5's physician, on 01/10/13 at 4:15 PM, revealed oxygen administration was intended to be continuous for the resident due to his/her diagnosis and the physician stated he was not aware the facility had removed the oxygen.</p> <p>Interview with the Director of Nursing (DON), on 01/10/13 at 4:15 PM, revealed she thought there was a verbal order obtained for an as needed order for oxygen for Resident #5 due to the expense of the oxygen. The DON revealed a potential for the oxygen saturation to drop. The DON also revealed she was ultimately responsible and had not been monitoring physician orders to ensure they were being followed. The DON further revealed orders were</p>	F 309	<p>This will be reported to the Evidence Based Committee monthly for 3 months and quarterly thereafter, if required. In addition, results will also be sent to Rehab and Skilled Unit Performance Improvement Committee.</p> <p>ADDENDUM TO #4 The monitor results of care planning, compliance with physician oxygen orders and accuracy of nurse aide report sheet and nurse report sheet will be reported by the Skilled Rehab's DON to the Evidence Based Committee (EBC) monthly to ensure 100% compliance for 3 consecutive months and then quarterly for 2013. The Evidence Based Committee (EBC) is the quality improvement/assurance committee for the facility. The EBC committee is comprised of all disciplines, including lab, radiology, therapies, quality/risk management, case management, acute care, intensive care, environmental services, clinical informatics and administration. The Rehab and Skilled Care unit's Medical Director is the Chair of the EBC and its administrator is a sitting member. The EBC will assess and monitor results and may make recommendations to implement changes or revisions to the processes when compliance is not 100%. In addition, results will be reported by the DON to the Rehab and Skilled Care Unit's QAPI Committee quarterly. This committee is comprised of the DON, MDS Coordinator, Activity Director/Social Service Designee, staff CNA, Staff LPN and RN, Nursing Home Administrator and Medical Director. The committee may make recommendations to implement changes or revisions to the processes as needed.</p>		



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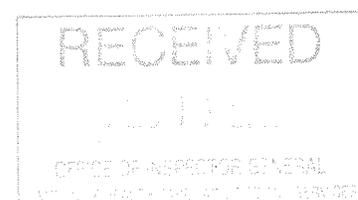
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F 309	Continued From page 16 checked monthly by a nurse and all variances should be followed up on; however, no audits were being done for accuracy.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to ensure appropriate supervision to prevent falls for two (2) of eight (8) sampled residents and two (2) unsampled residents. (Resident #4 and Resident #7). The findings include: Review of the facility's policy regarding Falls Risk Intervention Guidelines, revised 01/2011, revealed residents were to be considered a falls risk potential upon admission and general safety measures would be considered for implementation, when appropriate. When a resident was identified as at increased risk for falls based upon the nursing assessment, physician's evaluation or other supporting clinical documentation, high risk for falls precaution	F 323	1. Resident #4 is transferred with the use of 2 aides when mechanical hoyer lift used. The resident's chair was changed in order to provide a more secure means for transfer. In addition, the resident's spouse is no longer used for any transfer activity. Resident #7 fell both times due to bathroom/toileting issues. His care plan was updated on 11/27/12 and 1/11/13 to check more frequently, encourage to use the bathroom at every check and move bedside commode next to bed at night at resident's request. He has had no further falls. <u>ADDENDUM TO #1</u> DON or resident's RN/LPN immediately began verifying 2-person transfers on resident #4 by daily observation until cross-over sling lift obtained Attachment I 2. All residents being transferred via hoyer lift had their recliners changed. No other residents have been injured or fallen during transfer.	3/6/13 2-6-13 per [unclear] Bivins by PB 2/20/13



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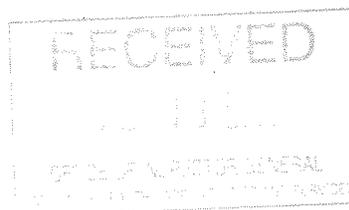
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185190	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER BAPTIST HOSPITAL NORTHEAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 NEW MOODY LANE LA GRANGE, KY 40031		
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F 323	<p>Continued From page 17</p> <p>strategies were considered. Interventions were to be included in the Individualized plan of care.</p> <p>Interview with the Risk Manager, on 01/09/12 at 12:05 PM, revealed the facility did not have a policy on the use of mechanical lifts.</p> <p>1. Observation of Resident #4, on 01/09/13 at 10:30 AM, revealed Registered Nurse (RN) #1 and Certified Nursing Assistant (CNA) #2 used a mechanical lift with a scoop type sling to transfer the resident from the bed to the reclining chair. RN #1 held onto the residents' legs during the transfer.</p> <p>Review of Resident #4's record revealed the facility admitted the resident on 05/30/12 with the following diagnoses: Subdural Hemorrhage post fall; Hypertension; Dementia; and Parkinsonism. Further record review revealed Resident #4 had fallen from a mechanical lift sling during a transfer, on 11/19/12, resulting in a laceration (cut) on the head requiring staples for closure. To prevent further falls, the facility added the use of the criss cross mechanical lift sling or use of two (2) staff with the mechanical lift during transfers.</p> <p>Interview with CNA #2, on 01/09/13 at 10:35 AM, revealed she was transferring the resident alone with the mechanical lift on 11/19/12 when the resident fell. CNA #2 revealed she was using the manual lift with a scoop type sling, was mid-transfer between the chair and the bed, when the resident stiffened his/her body and slid out of the sling onto the floor. The CNA revealed the resident was usually in the mechanical lift four times a day for transfers and had never had a problem before.</p>	F 323	<p>3. Mandatory In-service was held On January 29 and 30. Attachment A</p> <p>Staff was instructed not to allow family members to assist with transfers. They were also told to use only specified recliners for residents transferred with the mechanical lift.</p> <p>Falls Protocol educated to all Staff including:</p> <ul style="list-style-type: none"> • Falls Huddle • Components and Completion of the Post-Fall Order Set • Follow-up assessment • Labs and x-rays, when applicable • Documentation requirements • Updating of the care plan 		



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F 323	Continued From page 18 Interview with the Director of Nursing (DON), on 01/09/13 at 12:05 PM, revealed it was determined the type of mechanical lift being used during Resident #4's fall from the lift was the causal factor and was immediately replaced with another mechanical lift which would allow the lift to slide underneath the chair for positioning. The DON revealed use of the criss cross sling or the use of two (2) staff for transfer was also added to the care plan. The DON revealed Resident #4's spouse was being utilized as the second person to assist during transfers. Interview with Resident #4's spouse, on 01/10/13 at 1:54 PM, revealed he had assisted the staff with the use of the mechanical lift for Resident #4. The spouse revealed he had assisted with positioning, connecting the sling to the lift chair, and walking with the resident during the actual transfer. The spouse revealed the facility did not always utilize two (2) staff when using the mechanical lift for Resident #4 and he would be used as the second person assisting with the transfer. Interview with CNA #1, on 01/10/13 at 2:20 PM, revealed after Resident #4 fell out of the sling, the facility switched the type of mechanical lift used and they used two people for transfers. The CNA revealed the resident's spouse had been used as the second person during transfers instead of staff. Interview with Registered Nurse (RN) #3, on 01/10/13 at 3:00 PM, revealed Resident #4's spouse had been used as the second person for transfers stating the spouse walked beside the	F 323	A checklist was developed and Attached to the Falls Protocol to be completed by the nurse. The checklist includes: <ul style="list-style-type: none"> • each step of Falls Protocol • care plan updates. • The checklist is to be signed and dated by the nurse and turned into the DON when completed. <p>Attachment B</p> <p>In addition, a neuro flowsheet has been attached to the falls packet as both a reminder to complete neuro checks, as applicable, and to enable the next shift nurse to continue documentation and assessment.</p> <p>Attachment J</p> <p>ADDENDUM TO #3 Instructors were the DON and MDS Coordinator. The staff included all RN's, LPN's, CNA's, Activity Director, Assistant Activity Director and Unit Secretary. The in-service covered Falls Protocol, safe mechanical lift transfers, Oxygen orders, care plans and following MD orders. 100% of staff was in-serviced. Staff competency post-training was determined through demonstration and teach-back of information covered during the in-service.</p> <p>Attachment F Continued competency and compliance for Falls and Post-Fall Protocol and mechanical lift use will be accomplished by the DON auditing the Falls Checklist items for documentation completion and accuracy, with immediate follow-up with the nurse when not in compliance.</p>		



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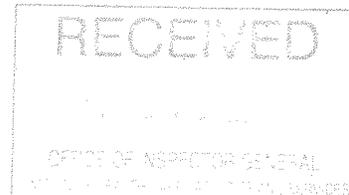
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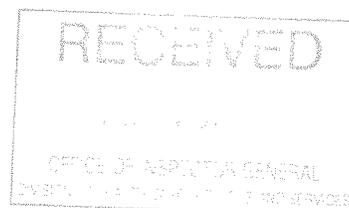
F 323	<p>Continued From page 19</p> <p>resident patting his/her hand. RN #3 revealed the spouse was not trained on the mechanical lift. RN #3 further revealed it was still safe to use the spouse because it was long term care which was more family oriented and if that was what worked then that was what the staff did.</p> <p>Interview with the DON, on 01/10/13 at 4:15 PM, revealed Resident #4's spouse probably should not have been used as the second person for transfers because it was the facility's responsibility to ensure the resident was transferred safely. The DON revealed she had discussed the idea of using the spouse with the MDS Coordinator, the Social Service Director/Activities Director and CNA #1, but did not discuss this with the Risk Manager and the Patient Safety Director. The DON revealed it had not occurred to her that utilizing the spouse could be unsafe for both the resident and the spouse. The DON revealed she was ultimately responsible for ensuring residents were transferred with the appropriate supervision to prevent falls.</p> <p>2. Observation of Resident #7, on 1/10/13 at 2:30 PM, revealed the resident was sitting in a recliner next to the bed reading an electronic book. The call light was draped over the arm of the chair and a yellow falls band was noted sitting on the bedside table. Interview with the resident at that time revealed he/she did not remember falling in the facility. The resident revealed he/she had refused the bed and chair alarm and felt he/she was still capable of doing things for himself/herself.</p>	F 323	<p>4. Director of Nursing or Activity Assistant will perform direct observation during resident transfers to verify compliance. The Post-Fall checklist is to be turned in to the DON after completion. The DON will audit the nursing documentation for all interventions listed, including the care plan update. This will be done with 100% of falls.</p> <p>Results will be reported to the Evidence Based Committee meeting monthly for 3 Months and quarterly thereafter, if required.</p> <p>Results will also be reported to the Unit Performance Improvement Committee. The expectation will be 100% compliance.</p> <p>ADDENDUM TO #4</p> <p>The monitor results of care planning, compliance with Falls Protocol and checklist with Falls Protocol will be reported by the Skilled Rehab's DON to the Evidence Based Committee (EBC) monthly to ensure 100% compliance for 3 consecutive months and then quarterly for 2013. The Evidence Based Committee (EBC) is the quality improvement/assurance committee for the facility. The EBC committee is comprised of all disciplines, including lab, radiology, therapies, quality/risk management, case management, acute care, intensive care, environmental services, clinical informatics and administration. The Rehab and Skilled Care unit's Medical Director is the Chair of the EBC and its administrator is a sitting member. The EBC will assess and monitor results and may make recommendations to implement changes or revisions to the</p>	
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F 323	<p>Continued From page 20</p> <p>Review of Resident #7's record revealed the facility admitted the resident on 10/09/12 with the following diagnoses: Leukemia, Chronic Obstructive Pulmonary Disease; Hypertension; and Congestive Heart Failure. Further record review revealed the resident fell on 11/17/12 and was found lying on the bathroom floor. Review of Resident #7's care plan revealed an intervention to reinforce the use of the bed and chair alarm was added on 11/17/12. Review of the Minimum Data Set, 10/21/12, revealed the resident had a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. Continued review of Resident #7's record revealed another fall the night of 11/22/12 resulting in a hematoma to the forehead. An order for every 2 hour neuro checks was noted, but no documented evidence of them being done was provided by the facility.</p> <p>Interview with Registered Nurse (RN) #2, on 01/10/13 at 11:30 AM, revealed on the night of 11/17/12 she heard some movement in Resident #7's room and found the resident lying on the bathroom floor. RN #2 revealed the resident did not have a bed alarm in place prior to the fall per the resident's request. RN #2 further revealed Resident #7 was very independent, alert and oriented, and refused to use a urinal, wear a fall alert bracelet, or have an alarm. RN #2 revealed she encouraged Resident #7 to call for assistance when getting up. RN #2 stated a post fall huddle was completed and nursing wanted Resident #7 to use a bed alarm but the resident refused. RN #2 revealed her shift did every 15 minute checks and kept the resident's room door open. RN #2 revealed she did not know what the other shift did for the resident to prevent falls and</p>	F 323	<p>processes when compliance is not 100%. In addition, results will be reported by the DON to the Rehab and Skilled Care Unit's QAPI Committee quarterly. This committee is comprised of the DON, MDS Coordinator, Activity Director/Social Service Designee, staff CNA, Staff LPN and RN, Nursing Home Administrator and Medical Director. The committee may make recommendations to implement changes or revisions to the processes as needed.</p>		



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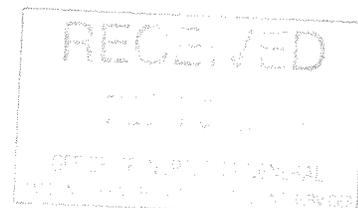
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F 323	<p>Continued From page 21</p> <p>she did not know what interventions were put into place to prevent further falls, as that was determined by the Director of Nursing. Further interview with RN #2 on 01/10/13 at 1:00 PM, revealed she had never seen a care plan on any of the residents and was not sure where they were even kept. RN #2 stated she relied on the information given in report to provide resident care.</p> <p>Interview with the DON, on 01/10/13 at 10:54 AM, revealed Resident #7 was alert and oriented. The DON revealed the resident did fall on the night of 11/17/12. When asked what was determined to be causal factors and root cause, the DON revealed a root cause analysis was not usually done on falls and she was not sure what interventions had been added to prevent further falls.</p> <p>Interview with RN #3, on 01/10/13 at 3:00 PM, revealed she was aware of Resident #7's fall and she stated Resident #7 had refused many interventions they had tried. RN #3 revealed she was on the facility's falls committee and the committee had discussed possible interventions during their meeting. RN #3 further revealed the Safety Committee Director notified the DON of possible interventions discussed; however, RN #3 stated she did not know what interventions were put into place to prevent further falls.</p> <p>Interview with the MDS Coordinator, on 01/10/13 at 4:50 PM, revealed she was responsible for adding the interventions to the care plan. The MDS Coordinator revealed she inserted interventions based on what she was told by the nurses or by reviewing the chart. The MDS</p>	F 323			



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F 323	Continued From page 22 Coordinator revealed there was currently no system in place to receive communication from the falls committee regarding interventions for falls. Interview with the DON, on 01/10/13 at 4:15 PM, revealed the facility utilized a post fall order set and performed a huddle after each fall. The DON revealed she was not able to determine if post fall neurochecks were completed after the second fall. The DON revealed an intervention to check the resident more frequently was discussed during the post fall huddle and that she did review the form which was forwarded to the Risk Manager. However, the DON revealed the MDS Coordinator was responsible to update the care plan and the MDS Coordinator was not made aware of items discussed during post fall huddle or the documentation. The DON revealed reinforcing the bed alarm was not an appropriate intervention for resident #7 after the first fall on 11/17/12, and she should have checked the care plans to ensure they were updated appropriately.	F 323			



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K 000	<p>INITIAL COMMENTS</p> <p>AMENDED LSC 02/15/13 Deleted K0054</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One wing of a three (3) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/09/13. Baptist Hospital Northeast was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for thirty (30) beds with a census of fourteen (14) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maisha N. Buser</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2-15-13</i>
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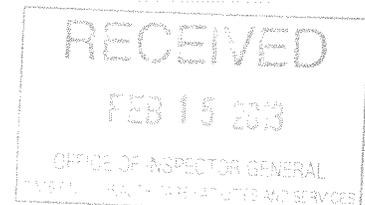
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 15 2013
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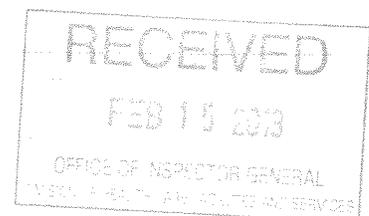
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at F level.	K 000	<i>K050</i> 1. No residents were harmed 2. Fire drills were done Quarterly as required by regulation. No residents were at risk.	<i>1/25/13</i>
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for thirty (30) beds with a census of fourteen (14) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times. The findings include: Fire Drill review, on 01/09/13 at 3:25 PM, with the	K 050	<u>ADDENDUM TO #2</u> Fire Drills were done monthly on the Rehab & Skilled Care Unit. The dates were 1/25/12, 2/22/12, 3/19/12, 4/30/12, 5/30/12, 6/26/12, 7/31/12, 8/28/12, 9/28/12, 10/23/12, 11/21/12, 12/21/12. No residents were at risk because fire drills were completed above & beyond regulation requirements. Attachment K 3. The engineering staff has been educated on the required timeframes per regulation for timing of the fire drills. <u>ADDENDUM TO #3</u> The electrician and HVAC mechanic were educated on January 24 by the Director of Engineering about the required timeframes per regulation for timing of the fire drills. ATTACHMENT L 4. The Director of Engineering will monitor that all fire drills are at staggered times per regulations. Compliance to be at 100% and reported to the Safety Committee Bi-monthly.	



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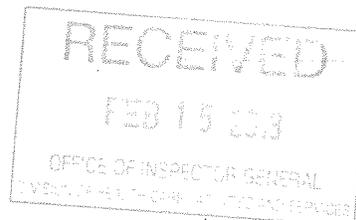
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K 050	<p>Continued From page 2</p> <p>HVAC Service Technician revealed the facility failed to conduct fire drills at unexpected times on first and second shifts.</p> <p>Interview, on 01/09/13 at 3:25 PM, with the HVAC Service Technician revealed they were not aware the fire drills were not being conducted as required.</p> <p>Interview, on 01/09/13 at 3:25 PM, with the facility Electrician revealed he was not aware of the requirements for conducting fire drills.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.</p>	K 050	<p>ADDENDUM TO #4</p> <p>The fire drills for the 2013 year have been scheduled and are in compliance with the staggered times regulations. The Director of Engineering will monitor that all fire drills take place at the scheduled times. Results will be reported by the Director of Engineering to the Safety Committee Bi-monthly. Compliance to be at 100%. The DON will also report results to the EBC Committee monthly times 3 months and then as required by results. The Evidence Based Care Committee is the quality improvement/assurance committee for the facility. The EBC committee is comprised of all disciplines, including lab, radiology, therapies, quality/risk management, case management, acute care, intensive care, environmental services, clinical informatics and administration. The Rehab and Skilled Care unit's Medical Director is the Chair of the committee and its administrator is a sitting member. The EBC will assess results and make recommendations when compliance is not 100%. In addition, results will be reported by the DON to the Rehab and Skilled Care Unit's QAPI Committee quarterly. The committee will make recommendations and changes as needed</p>	



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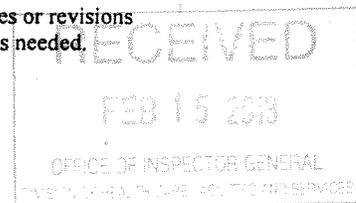
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2013
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K 061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure valves located in the facility sprinkler system were supervised by a tamper switch. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility has thirty (30) certified beds with a census of fourteen (14) on the day of the survey. The facility failed to install a tamper switch on the post indicator valve for the sprinkler system.</p> <p>The findings include:</p> <p>Observation, on 01/09/13 at 2:45 PM, with the HVAC Service Technician revealed the post indicator valve located outside by the loading dock was not equipped with a tamper switch to notify the facility if the valve was closed.</p> <p>Interview, on 01/09/13 at 2:45 PM, with the HVAC Service Technician revealed he was not aware the main valve on the sprinkler system was not supervised.</p> <p>Interview, on 01/13/13 at 2:45 PM, with the facilities electrician confirmed the observation.</p>	K 061	<p>1. No residents were harmed</p> <p>2. No residents were found to be at risk.</p> <p>ADDENDUM TO # 2</p> <p>There are only 2 post-indicator valves in the facility requiring a tamper switch. One already has a tamper-switch and is tied into the fire alarm panel. In addition, the sprinkler system valve that was cited as deficient is checked monthly by the engineering department that is it in good working order and has not been tampered with. The fire alarm and sprinkler were both working so no residents were at risk.</p> <p>Attachment P</p> <p>3. Simplex Grinnell has been issued a Purchase Order and the switch is scheduled to be installed and activated by Simplex Grinnell by 2/15/2013. Compliance date is 2/16/2013. Attachment Q</p> <p>4. The device will be tested by the fire alarm panel quarterly and documented in the quarterly inspection report. Findings will be reported to Safety Committee Bi-monthly.</p>	2/15/13	



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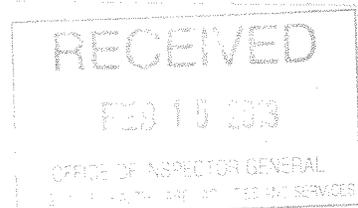
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K 061	Continued From page 4 Reference: NFPA 101 (2000 Edition). 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061	ADDENDUM TO #4 - K061 The fire alarm panel will be tested by Simplex Grinnel The Director of Engineering will report monitor results to the Safety Committee bi-monthly to ensure 100% compliance for 3 consecutive months. The DON will also report results to the EBC Committee monthly to ensure 100% compliance for three consecutive months. The Evidence Based Committee (EBC) is the quality improvement/assurance committee for the facility. The EBC committee is comprised of all disciplines, including lab, radiology, therapies, quality/risk management, case management, acute care, intensive care, environmental services, clinical informatics and administration. The Rehab and Skilled Care unit's Medical Director is the Chair of the EBC and its administrator is a sitting member. The EBC will assess and monitor results and may make recommendations to implement changes or revisions to the processes when compliance is not 100%. In addition, results will be reported by the DON to the Rehab and Skilled Care Unit's QAPI Committee quarterly. This committee is comprised of the DON, MDS Coordinator, Activity Director/Social Service Designee, staff CNA, Staff LPN and RN, Nursing Home Administrator and Medical Director. The committee may make recommendations to implement changes or revisions to the processes as needed.		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, sprinkler testing record review, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency	K 062			



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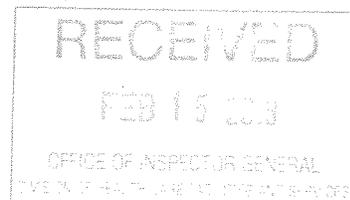
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K 062	<p>Continued From page 5</p> <p>had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for thirty (30) beds with a census of fourteen (14) on the day of the survey. The facility failed to provide a sprinkler head wrench, and complete required testing for the sprinkler system.</p> <p>The findings Include:</p> <p>1. Observation, on 01/09/13 at 2:43 PM, with the HVAC Service Technician revealed the facility did not have a sprinkler head wrench located in the spare sprinkler head box.</p> <p>Interview, on 01/09/13 at 2:43 PM, with the HVAC Service Technician revealed he was not aware the sprinkler wrench had been removed from the spare sprinkler head box.</p> <p>Interview, on 01/09/13 at 2:43 PM, with the facility Electrician confirmed the observation.</p> <p>2. Sprinkler Testing Record Review, on 01/09/13 at 3:35 PM, with the HVAC Service Technician revealed the facility did not have an internal pipe inspection performed within the last five years.</p> <p>Interview, on 01/09/13 at 3:35 PM, with the HVAC Service Technician revealed he was not aware of the requirement.</p> <p>Interview, on 01/09/13 at 2:43 PM, with the facility Electrician revealed he was not aware of the requirement.</p>	K 062	<p>1. No residents were harmed.</p> <p>2. No residents were found to be at risk.</p> <p>ADDENDUM TO # 2 The wrench was available for use any time it was needed but was on top of the sprinkler box instead of in it. There were no fires or fire alarms sounded during the year except those for drills. The gauges were changed on 1/16/13. Pressures between the old and new gauges were consistent proving the old gauges were in good working order so systems would have worked and no residents were at risk. Attachment R</p> <p>3. The wrench was located on top of the sprinkler head box at the time of the survey. The wrench has now been placed in the box. The Internal Pipe Inspection on the sprinkler riser have been calibrated and the gauges replaced. Both were completed on 1/16/2013. Attachment S</p>
			1/17/13



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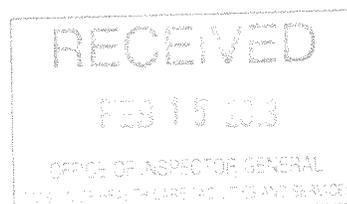
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K 062	<p>Continued From page 6</p> <p>3. Sprinkler Testing Record Review, on 01/09/13 at 3:35 PM, with the HVAC Service Technician revealed the facility did not have documentation that the gauges on the sprinkler riser had not been calibrated or replaced within the last five years.</p> <p>Interview, on 01/09/13 at 3:35 PM, with the HVAC Service Technician revealed he was not aware of the requirement.</p> <p>Interview, on 01/09/13 at 3:35 PM, with the facility Electrician revealed he was not aware of the requirement.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing</p>	K 062	<p>4. Director of Engineering will monitor monthly to ensure wrench is in place times 3 months. Compliance to be at 100%. A PM was generated to remind Director of next 5 year internal inspection is due 1/1/2018. The Director of Engineering will report findings to the Safety Committee bi-monthly. The Safety Committee is comprised of members from disaster preparedness, ED, DON of Rehab and Skilled Care, HR, Quality/Risk Management, Environmental Services and Radiology. They will make recommendations and/or revisions as required by results.</p>	



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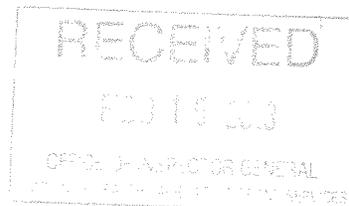
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K 062	Continued From page 7 shall comply With 5-5.5.2. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062	ADDENDUM TO #4 The Director of Engineering will report to the Safety Committee bimonthly and the DON will report results to the to the EBC Committee monthly to ensure 100% compliance for 3 consecutive months. The Evidence Based Care Committee is the quality improvement/assurance committee for the facility. The EBC committee is comprised of all disciplines, including lab, radiology, therapies, quality/risk management, case management, acute care, intensive care, environmental services, clinical informatics and administration. The Rehab and Skilled Care unit's Medical Director is the Chair of the committee and the nursing home administrator is a sitting member. The EBC will assess results and make recommendations when compliance is not 100%. In addition, results will be reported by the DON to the Rehab and Skilled Care Unit's QAPI Committee quarterly. This committee is comprised of the DON, MDS Coordinator, Activity Director/Social Service Designee, staff CNA, Staff LPN and RN, Nursing Home Administrator and Medical Director. The committee will make recommendations and changes as needed.		



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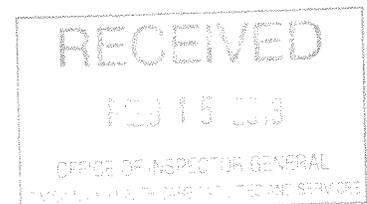
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K 062	<p>Continued From page 8</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected,</p>	K 062		



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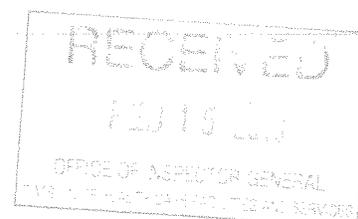
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K 062	Continued From page 9 tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1	K 062			



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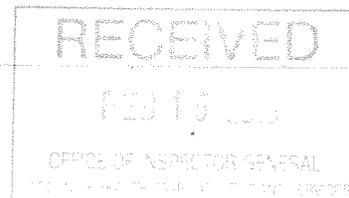
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K 062	Continued From page 10 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		1/31/13
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is certified for thirty (30) beds with a census of fourteen (14) on the day of the survey. The facility failed to ensure the proper use of power strips and extension cords. The findings include: Observations, on 01/09/13 between 1:30 PM and 3:30 PM, with the HVAC Service Technician revealed: 1) A refrigerator was plugged into a power strip located in the Activities Office. 2) Medical equipment was plugged into a power strip located at the Nurse's Station. 3) An extension cord was being used with a lamp located in room #P1231. Interview, on 01/09/13 between 1:30 PM and 3:30 PM, with the HVAC Service Technician revealed	K 147	K147 1. No residents were harmed. 2. The extension cord was immediately removed from room 1231. No other residents were found to be at risk. <u>ADDENDUM TO #2</u> All rooms and offices were inspected. No other extension cords were found in use. No other appliance with compressor was plugged into a power strip. 3. The refrigerator plug was removed from the power strip and plugged into a wall outlet. A new wall outlet was installed at the nurse's station on. The medical equipment, Accucheck machine chargers, were removed from the power strip and plugged into outlets. Mandatory In-services held. Skilled Rehab staff was educated about proper use of extension cords and power strips	



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K 147	Continued From page 11 they were aware of the proper use of power strips and extension cords but it is hard to monitor. Interview, on 01/09/13 between 1:30 PM and 3:30 PM, with the facility Electrician revealed they were aware of the proper use of power strips and extension cords. Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number	K 147	<u>ADDENDUM TO #3</u> The wall outlet was installed in the nurse's station on 1/29/13. Mandatory In-services held on January 29 & 30 by the DON. Skilled Rehab RN's, LPN's, CNA's, Activity Director, MDS Coordinator and Activity Assistant were educated about proper use of extension cords and power strips by the DON. They were told no extension cords were allowed in patient rooms and no medical equipment is to be plugged into power strips. In addition, no appliances with compressors can be plugged into power strips. Competency was assessed by verbalization/ Teach-back. Attachment F 4. The Director of Engineering will monitor resident rooms for extension cord use on the Rehab Skilled Unit on a monthly Preventative Maintenance. DON of Skilled Rehab will monitor for compliance re: medical equipment. Compliance will be reported to The Safety Committee bi-monthly.	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2013
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K 147	Continued From page 12 of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	<p>ADDENDUM TO #4</p> <p>The Safety Committee is comprised of members from disaster preparedness, ED, DON of Rehab and Skilled Care, HR, Quality/Risk Management, Environmental Services and Radiology. They will make recommendations and/or revisions as required by results.</p> <p>The DON will also report results to the EBC Committee monthly to ensure 100% compliance for 3 consecutive months. The Evidence Based Care Committee is the quality improvement/assurance committee for the facility. The EBC committee is comprised of all disciplines, including lab, radiology, therapies, quality/risk management, case management, acute care, intensive care, environmental services, clinical informatics and administration. The Rehab and Skilled Care unit's Medical Director is the Chair of the committee and the nursing home administrator is a sitting member. The EBC will assess results and make recommendations to implement changes or revisions to the processes when compliance is not 100%. In addition, results will be reported by the DON to the Rehab and Skilled Care Unit's QAPI Committee quarterly. This committee is comprised of the DON, MDS Coordinator, Activity Director/Social Service Designee, staff CNA, Staff LPN and RN, Nursing Home Administrator and Medical Director. The committee will make recommendations to implement changes or revisions to the processes as needed.</p>	
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Attachment T

