



PRINTED: 01/27/2014  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/23/2014
NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An Abbreviated/Partial Extended Survey investigating complaint #KY21060 and #KY21061 was conducted on 12/09/13 through 12/20/13 to determine the facility's compliance with Federal requirements. KY21060 was substantiated with deficiencies cited. KY21061 was unsubstantiated with no deficiencies cited. Immediate Jeopardy was identified on 12/13/13, and determined to exist on 11/30/13 at 42 CFR 483.10 Resident Rights, F157; 42 CFR 483.20 Resident Assessment, F281; and 42 CFR 483.25 Quality of Care, F309 at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 12/13/13.</p> <p>On 11/29/13, when Registered Nurse (RN) #1 came on duty at 7:00 PM, she was made aware Resident #1 was a little lethargic and she needed to obtain urine for as Urinalysis because the physician thought the resident might have a Urinary Tract Infection (UTI). On 11/30/13 at approximately 5:00 AM, a Certified Nurse Aide (CNA) reported to RN #1 that Resident #1 was having diarrhea, was not drinking fluids and she was unable to arouse the resident easily. RN #1 stated she called and left a message for the physician sometime between 5:30 AM-6:00 AM; however, there was no documented evidence the physician was notified. Further interview revealed RN #1 and RN #2 discussed notifying the physician again, but decided not to attempt to notify the physician again. At 6:00 AM, the physician called the facility and RN #1 received orders for a Complete Blood Count (CBC),</p>	F 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	01/24/14	

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

TITLE

*V. Edward Foley*

*Regional Administrator*

02/12/14

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

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F 000	Continued From page 1 Comprehensive Metabolic Profile (RCMP), Urinalysis (UA), chest x-ray, intravenous fluids (IV), Normal Saline at 90 cubic centimeters (cc) per hour (hr), and IV Flagyl (an antibiotic) 500 milligrams (mg) three times a day (TID). There was no documented evidence RN #1 conducted ongoing assessments to include monitoring vitals signs, for signs and symptoms of dehydration, change in level of consciousness, shortness of breath, and cyanosis per Resident #1's plan of care from the time RN #1 came on duty on 11/29/13 at 7:00 PM until the day shift LPN assessed the resident on 11/30/13 at 7:30 AM. In addition, there was no documented evidence RN #1 initiated the physician ordered IV therapy timely. The IV therapy was not initiated until 7:00 AM when Licensed Practical Nurse (LPN) #2 (day shift LPN) arrived at the facility. LPN #2 initiated the IV in the resident's right arm and Normal Saline was started at 90 cc's an hour. LPN #1 (day shift nurse) entered the resident's room at 7:30 AM to implement the physician's order for the UA. LPN #1 noted Resident #1 was having difficulty breathing, the resident's feet, knees and hands were mottled and Resident #1 was not responding. LPN #1 initiated oxygen (O2) at two (2) liters and conducted an in and out catheterization for urine for the UA. Approximately five to seven ccs of dark tea colored urine was obtained. The resident's blood pressure (B/P) was 55/24 (normal range is 120/70), O2 saturation was 81% (normal range 98-100%) before O2 started, Resident #1 was mouth breathing, pulse was 47 (normal range 70), respirations were 24 (normal 20), and temperature was 97.1 (normal 98.6). The physician was called and the resident was sent to the emergency room for evaluation. The Paramedic's initial assessment at the facility at	F 000			

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F 000	Continued From page 2 8:30 AM revealed Resident #1 IV fluids were not infusing. The resident was diagnosed with Respiratory Failure, Dehydration, Hypotension and Gastrointestinal Bleeding per rectum. Resident #1 was admitted to the Intensive Care Unit, Coded and passed away at 4:42 PM.  An acceptable Allegation of Compliance (AoC) was received on 12/19/13 alleging the removal of the Immediate Jeopardy on 12/20/13. The State Survey Agency validated, on 12/20/13, the Immediate Jeopardy had been removed on 12/20/13, as alleged. The scope and severity was lowered to a "D" at 42 CFR 483.10 Resident Rights, F157; 42 CFR 483.20 Resident Assessment, F281; and 42 CFR 483.25 Quality of Care, F309 while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.  The investigation was reopened on 01/16/14 and concluded on 01/23/14 and determined deficient practice also existed at 42 CFR 483.20 Resident Assessment at F282 at a S/S of a "J".	F 000	F157 1. Resident # 1 was discharged from the facility on 11-30-2013. 2. All current residents of the facility were reviewed by the Interdisciplinary Team to include the Director of Nursing, Unit Managers for halls one and two and Assistant Director of Nursing, MDS Coordinator and Social Services Director to assure that any current resident who is experiencing a significant change in condition had physician notification. Any identified as having had a significant change in condition in the past thirty (30) days without physician notification had immediate physician notification. This included a set of vital signs and visual examination of the resident for apparent acute distress by the Director of Nursing, Assistant Director of Nursing or Unit Managers and a review of the medical record for the past thirty (30) days by the Interdisciplinary Team. This was completed on 12/14/2013. All concerns were immediately addressed. 3. On 12/14/2013 the Regional Nurse Consultant re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for hall one and two on the interact process and timely notification of the physician and using the Medical Director if unable to reach the attending physician timely including calling 911 in an emergency situation. The Interact process is evidence based practice program developed at the request of the Centers for Medicaid and Medicare Services to reduce unnecessary return hospitalizations. The Regional Nurse Consultant also re-educated the Director of	
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or	F 157		

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F 157	<p>Continued From page 3</p> <p>clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the resident's record, nursing notes, Interdisciplinary Team Note, physician's orders, hospital's Emergency Department Physician Chart, and facility's policy/procedure, it was determined the facility failed to immediately consult with the physician when there was a significant change in condition; and the Registered Nurse's (RN) inability to start treatment for one (1) of five (5) sampled residents (Resident #1).</p> <p>On 11/30/13 at approximately 5:00 AM, a Certified Nurse Aide (CNA) reported to RN #1 that Resident #1 was having diarrhea, did not want to drink and was not easily aroused. RN #1</p>	F 157	<p>Nursing, Assistant Director of Nursing and Unit Managers for units one and two on notification of the physician if the nurse was unable to follow MD orders in a timely manner. Beginning 12/14/2014 all licensed staff was re-educated on immediate notification of the physician with a significant change in condition using the interact process as a guideline, but not to supersede the judgment of the nurse in attendance. In addition, the education included notification of the Medical Director if they were unable to reach the attending physician timely. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12-14-2013 without having received this education.</p> <p>On 12/14/2013 the Regional Nurse Consultant provided education to the Director of Nursing and the Unit Manager for hall one related to skill procedures for IV insertion, emergency oxygen administration, and airway obstruction with competency testing. The Director of Nursing or Unit Manager for hall one will provide training to all licensed nurses on IV insertion, emergency oxygen administration and airway obstruction with competency testing. No staff will work after 12/19/2013 without having received this education and validation competency.</p> <p>4. The Director of Nursing or Unit Manager for hall one will review the twenty four hour report and all physician orders daily for two (2) weeks, followed by five (5) times per week for at least ten (10) weeks to assure all changes in condition have appropriate</p>		

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F 157	Continued From page 4 called the physician and left a message between 5:30-6:00 AM. However, RN #1 discussed the physician not calling them back with RN #2 and they decided not to attempt to notify the physician again. At 6:00 AM, RN #1 received orders for a Complete Blood Count (CBC), Comprehensive Metabolic Profile (CMP), Urinalysis (UA), chest x-ray, Intravenous Fluids (IV) Normal Saline at 90 cubic centimeters (cc) per hour (hr), and IV Flagyl (an antibiotic) 500 milligrams (mg) three times a day (TID). RN #1 failed to notify the physician that she did not attempt to start the IV because she felt she couldn't start it because the resident was so dehydrated. When Licensed Practical Nurse (LPN) #1 (day shift nurse) went to the resident's room between 7:00 AM-7:30 AM to carry out the physician's orders, she noted Resident #1 was having difficulty breathing. The resident's feet, knees and hands were mottled and the resident was not responding. LPN #1 initiated oxygen (O2) at two (2) liters and performed an in and out catheterization for urine for the UA. The nurse obtained approximately five to seven (5-7) cc's of dark tea colored urine. The resident's blood pressure (B/P) was 55/24 (normal range:120/70), O2 saturation was 81% (normal range: 98-100%) before the oxygen was started. Resident #1 was mouth breathing, pulse was 47 (normal range: 70), respirations were 24 (normal range 20), and his/her temperature was 97.1 (normal 98.6). LPN #2 initiated the IV in the resident's right arm and started Normal Saline at 90 cc's per hour. LPN #1 attempted to contact the physician at 7:30 AM to send the resident out to the hospital with no success. The LPN did not call the physician back until 8:00 AM-8:15 AM and at that time, she received orders to send the resident to the emergency room for evaluation. The resident was admitted to the hospital with	F 157	physician notification, assessment and follow up. In addition the Director of Nursing, Assistant Director of Nursing, or Unit Manager for hall one will contact the faculty each shift to review with each nurse any significant changes in resident condition to assure licensed staff are assessing and notifying the physician timely. This occurred daily for two (2) weeks followed by five (5) times per week for at least ten (10) weeks on each shift. All monitoring will be reviewed weekly by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Social Services Director Unit Managers for hall one and two, Dietary Service Manager with the Medical Director attending at least Quarterly.	01/24/14	

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F 157	<p>Continued From page 5</p> <p>diagnoses of Respiratory Failure, Dehydration, Hypotension and Gastrointestinal Bleeding per rectum. Resident #1 was admitted to the Intensive Care Unit, Coded and passed away at 4:42 PM.</p> <p>The facility's failure to immediately notify the resident's physician of a significant change in condition and the inability to start treatment has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 12/13/13, and was determined to exist on 11/30/13. The facility was notified of the Immediate Jeopardy on 12/13/13. An acceptable Allegation of Compliance (AoC) was received on 12/19/13 and the State Survey Agency validated the Immediate Jeopardy had been removed on 12/20/13, as alleged. A partial extended survey was conducted on 12/20/13. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure "Change in Condition", dated 01/11, revealed a change of condition in a resident should target many areas of the Interdisciplinary Team (IDT) function. To ensure the optimal outcome for the resident, the nursing process of Assessment, Plan, Intervention, and Evaluation will be used. Physician involvement is always required, as is follow-up assessment per Federal Guidelines. Process: Interact 11 system is to be used with this protocol. Change in condition Assessment Guidelines will be followed by the licensed nurse</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>for the initial, and when necessary the follow-up assessment to detect change in condition by symptoms and categories. Interact tool "Immediate Notification" revealed any symptom, sign or apparent discomfort that is acute or sudden in onset, and a marked change (more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. All information triggers in this reference will be used when notifying the physician. A Situation-Background-Assessment/Appearance Request (SBAR) form is to be used for documentation prior to notifying the physician. This form will contain information gathered when doing an assessment and is to be utilized as a Nursing Note in the medical record. Notification of Resident Change in Condition: Clinicians will immediately consult with the resident's physician when there is a significant change in condition. Document in the Nurses' Notes the times notification was made and the names of the person(s) to whom you spoke.</p> <p>Record review revealed the facility admitted Resident #1 on 12/31/08 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension (HTN) Not Other Specified (NOS), Chronic Ischemic Heart Disease, Senile Dementia Uncomplicated, Depressive Disorder NEC, Anemia NOS, Urinary Incontinence NOS, Tuberculosis (TB) of Bronchus, unspecified. Review of the Minimum Data Set (MDS) assessment, dated 10/07/13, revealed the facility assessed Resident #1's cognition as severely impaired. Review of the physician orders, dated 11/01/13 through 11/30/13, revealed Resident #1 was a full code.</p> <p>Interview with CNA #1, on 12/13/13 at 7:05 AM,</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>revealed she reported to RN #1, on 11/30/13 at approximately 5:00 AM, that Resident #1 was having diarrhea, did not want to drink anything, and was not easily aroused.</p> <p>Review of the nursing notes for 11/30/13 revealed there was no evidence the physician was notified of the resident's change in condition.</p> <p>Interview with RN #1, on 12/10/13 at 12:42 PM, and on 12/13/13 at 7:36 AM, revealed CNA #1 had reported to her that Resident #1 was having diarrhea and was not wanting to take fluids. RN #1 stated around 5:00 AM, she assessed and checked Resident #1's vital signs. RN #1 stated Resident #1's blood pressure was eighty something over fifty something; however, she could not remember the specifics and she did not document this assessment. RN #1 stated she contacted the on-call physician and left a message between 5:30 AM and 6:00 AM. RN #1 stated she then started administering the morning medications and did not call the physician back when he did not return her call. Further interview revealed she discussed the physician not calling her back with RN #2 and they decided not to call the physician again. The RN stated she received a return call from the physician at 6:00 AM with orders for labs, an x-ray, IV fluids, and medications. RN #1 stated she did not start the IV because Resident #1 was dehydrated and wasn't drinking and she did not have a lot of experience with starting an IV on someone that was dehydrated. Another reason she did not start the IV was due to not having "good feeling" in her fingertips. She stated in the past when she started an IV in the facility she always had another nurse with her. The RN revealed she did not notify the physician she was unable to start</p>	F 157		

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F 157	<p>Continued From page 8</p> <p>the IV. She stated sha knew the day shift nurse would assist when she arrived. RN #1 stated she asked RN #2 for assistance a few different times during her shift; however, RN #2 could not help due to having issues going on with her residents and she was in the middle of a medication pass. She stated she asked RN #2 what to do since when was unable to contact the physician and they decided to wait for the physician to call back. The RN stated everything was happening around 5:00 AM-5:30 AM, and she felt overwhelmed. RN #1 stated she was not familiar with the interact process related to the gathering of information to notify the physician.</p> <p>Interview with RN #2, on 12/12/13 at 6:03 PM, revealed she worked the night Resident #1 was sick and had to be sent to the hospital. She stated RN #1 had came over and told her Resident #1 was confused and had a change in condition. RN #2 stated she told RN #1 to obtain the resident's vital signs and call the physician. The RN stated this was before 6:00 AM and RN #1 never came back after that.</p> <p>Review of a physician's telephone order, dated 11/30/13 at 6:00 AM, revealed orders for a CBC, CMP, a UA now, chest x-ray, IV Normal Saline at 90 cc's hr, and IV Flagyl 500 TID.</p> <p>Review of the Interdisciplinary Team Notes, dated 11/30/13 at 1:13 PM, revealed at 7:30 AM, LPN #1 called mobile x-ray for a stat chest x-ray. Further review revealed when LPN #1 entered Resident #1's room to obtain the urine for the UA she observed Resident #1 was having difficulty breathing. The resident's feet, knees and hands were mottled and the resident was not responding. LPN #1 initiated oxygen (O2) at two</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>(2) liters and conducted an in and out catheterization for urine for the UA. The nurse obtained approximately five to seven cc's of dark tea colored urine. The resident's blood pressure (B/P) was 55/24 (normal 120/70), O2 saturation was 81% (normal 98-100%) before O2 started, and Resident #1 was mouth breathing. Another nurse initiated the IV in the resident's right arm, Normal Saline was started at 90 cc's an hour. LPN #1 continued to take the resident's B/P and it was down to 55/24, pulse was 47 (normal 70), respirations 24 (normal 20), temp 97.1 (normal 98.7). The physician was called at 8:15 AM and advised of Resident #1's condition and code status. The Physician stated to send Resident #1 to the emergency room for evaluation.</p> <p>Interview with LPN #1, on 12/10/13 at 10:30 AM and on 12/12/13 at 4:10 PM, revealed she arrived at work at shift change and was told by RN #1 an IV needed to be started. LPN #1 stated RN #1 stated Resident #1 wasn't doing well. The LPN stated she could see that RN #1 was really overwhelmed and behind so she started helping. She stated when she entered Resident #1's room, the resident was pale, would not respond to staff, but would moan when touched. The LPN stated she checked the resident's vital signs after she did the in and out catheter to obtain the urine for the UA. The LPN stated the vital signs were abnormal. She stated the resident's B/P was "like 55 over something" and she noted Resident #1 had mottling. The physician was called to get an order to send Resident #1 to the hospital at approximately 7:30 AM with no response from the physician. LPN #1 stated she did not call the physician back until 8:00 AM or 8:15 AM and at that time, she received orders to send Resident #1 to the hospital for evaluation.</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>Review of the hospital's Emergency Department Physician Chart revealed Resident #1 was admitted to the hospital on 11/30/13, with diagnoses of Respiratory Failure, Dehydration, Hypotension and Gastrointestinal Bleeding per rectum. Interview with the Hospital Social Worker, on 12/10/13 at 9:03 AM, revealed the resident was admitted to the Intensive Care Unit, Coded and passed away at 4:42 PM.</p> <p>Interview with the Director of Nursing (DON), on 12/11/13 at 2:15 PM, revealed if the nurse was unable to reach a physician, the nurse should have tried again to notify the physician. She stated she expected a return call from the physician within thirty (30) minutes. The DON stated the facility did not have a policy with a specific time, nursing was to use their judgement. She stated there was no documentation as to the time the physician was notified.</p> <p>Interview with the on-call physician, on 12/10/13 at 3:04 PM, revealed he was contacted regarding Resident #1 and orders were given to the nurse. He stated the RN told him Resident #1 was having diarrhea and loose watery stools.</p> <p><b>**The facility implemented the following actions to remove the Immediate Jeopardy:</b></p> <p>On 12/14/13, the Regional Director of Operations re-educated the Administrator related to the responsibility of the Administrator to oversee the facility in accordance with Federal regulations to include monitoring of the Director of Nursing related to the supervision of nursing staff. On 12/14/13, the Administrator re-educated the</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>Director of Nursing on the requirements to supervise nursing staff to include guidance and direction for new nurses as well as follow up questions in communications with the nursing staff. On 12/14/13, the Regional Nurse Consultant re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for hall one and two on the Interact Process, timely notification of the physician and using the Medical Director if unable to reach the attending physician timely including calling 911 in an emergency situation. The Interact Process is an evidence based practice program developed at the request of the Centers for Medicaid and Medicare Services to reduce unnecessary return hospitalizations. The Regional Nurse Consultant also re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for units one and two on notification of the physician if the nurse was unable to follow MD orders in a timely manner. It includes suggestions for nurses on when to notify the physician and what recommendations for treatments to make, but does not override the judgement of the nurse at bedside.</p> <p>Resident #1 was discharged from the facility on 11/30/13. All Current residents of the facility have been reviewed by the Interdisciplinary Team (IDT) to include the Director of Nursing, Unit Managers for halls one and two, Assistant Director of Nursing, MDS Coordinator and Social Services Director, to assure that any current resident who is experiencing a significant change in condition had physician notification. Any resident who was deemed to have had a significant change in condition in the past thirty (30) days without physician notification had immediate physician notification. This review included a set of vital</p>	F 157			

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F 157	<p>Continued From page 12</p> <p>signs and visual examination of the resident for apparent acute distress by the Director of Nursing, Assistant Director of Nursing or Unit Managers; and, a review of the medical record for the past thirty (30) days by the IDT. This was completed on 12/14/13.</p> <p>The IDT, which included the Director of Nursing, Unit Managers, MDS Coordinator and Social Services Director, reviewed all current residents' care plans on 12/14/13 to assure that the care plan was up to date and met the needs of the resident, and that the care plan interventions were in place. Any resident whose care plan was not up to date to meet the needs of the resident had the care plan updated. Any interventions not in place were implemented.</p> <p>Beginning 12/14/13, all licensed staff was re-educated on immediate notification of the physician with a significant change in condition using the Interact Process as a guideline, but not to supercede the judgement of the nurse in attendance. In addition, the education included notification of the Medical Director if they were unable to reach the attending physician timely. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this education.</p> <p>Beginning on 12/14/13, all licensed staff was re-educated on the completion of appropriate nursing assessments with follow up based upon the resident's condition with examples of abnormal vital signs, respiratory and gastro-intestinal using the Interact guidelines and pathways as a guide, not to supercede the</p>	F 157			

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F 157	<p>Continued From page 13</p> <p>judgement of the nurses in attendance. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this re-education.</p> <p>On 12/14/13, the Regional Nurse Consultant will provide education to the Director of Nursing and the Unit Manager for hall one related to skill procedures for IV insertion, emergency oxygen administration, and airway obstruction with competency testing. The Director of Nursing or Unit Manager for hall one will provide training to all licensed nurses on IV insertion, emergency oxygen administration and airway obstruction with competency testing. No staff will work after 12/19/13, without having received this education and validation competency.</p> <p>An Ad Hoc Quality Assurance Committee meeting (QPI) was held on 12/14/13 to review the alleged deficient practice as well as the plan for removal to include audits for care plans and care plan interventions to assure care plans meet the needs of the residents and interventions are followed, and all training material presented to licensed staff. The discussion also included training completed for the Administrator and the Director of Nursing and how the facility will monitor corrective actions. In attendance was the Administrator, the Director of Nursing, the Assistant Director of Nursing, Unit Manager, MDS Nurse and the Social Service Director. The Medical Director attended via conference call. No further recommendations were made by the committee. The Quality Assurance Committee will meet weekly to review the removal plan as well as monitoring of actions weekly until substantial</p>	F 157			

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F 157	<p>Continued From page 14 compliance is achieved.</p> <p>Monitoring of the allegation of compliance will be conducted by doing the following: The Director of Nursing or Unit Manager for hall one will review the Twenty Four Hour Report and all physician orders daily for two weeks, followed by five times a week for at least ten weeks to assure all changes in condition had appropriate physician notification, assessment and follow up. In addition, the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall one will contact the facility once each shift to review with each nurse any significant changes in resident condition to assure licensed staff are assessing and notifying the physician timely. This will occur daily for two weeks, followed by five times per week for at least ten weeks on each shift. The Administrator will speak with all new nurses within the first thirty (30) days of employment and at least five nurses per month for three months to assure training needs are met as well as to assure communication with the Director of Nursing is open and appropriate. The Director of Nursing will audit five resident records per week for twelve weeks to ensure that the care plans meet the needs of the resident and care plan interventions are followed.</p> <p>All monitoring will be received weekly by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Social Services Director, Unit Managers for hall one and two, the Dietary</p>	F 157		

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F 157	<p>Continued From page 15</p> <p>Services Manager and the Medical Director attending at least quarterly. Failure to comply with any of the above will result in individual re-training and as appropriate disciplinary action. The Center alleges by the above actions that the immediate Jeopardy was abated for all residents on 12/20/13.</p> <p><b>**The State Survey Agency validated the corrective action taken by the facility as follows:</b></p> <p>Review of an in-service provided to the Administrator on 12/14/13 revealed the Administrator was inserviced on the Administration, Supervision and monitoring of system implementation to understand administrative duties and Federal regulations. The supervision of the DON and other direct reports and the method and frequency of system monitoring.</p> <p>Review of an in-service provided to nursing staff on 12/14/13 revealed it included physician notification regarding a resident change in condition, completion of appropriate nursing assessments and follow up, Interact Process review, notification of the physician, call the Medical Director if unable to reach the attending physician timely and to call 911 in an emergency, with no need to call the physician first.</p> <p>Review of the Regional Director Officer's education of the Administrator revealed the Administrator was educated on 12/14/13 related to monitoring the DON's supervision of the nursing staff to include guidance and direction for new nurses and follow up communication.</p> <p>Review of the Regional Nurse Consultant's</p>	F 157		

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F 157	<p>Continued From page 16</p> <p>re-education of the DON, ADON and Unit Managers for halls one and two on 12/14/13 revealed it included: the Interact Process, timely notification, using the Medical Director, and calling 911 if unable to follow physician orders.</p> <p>Review of all residents' assessments performed on 12/14/13 revealed an assessment was conducted which included vital signs and visual examinations. Physician notification was completed if needed for a change in condition by the DON, ADON and Unit Managers. The results were reviewed by the IDT.</p> <p>Review of inservices conducted on 12/14/13 revealed all staff received the inservices, except for two staff who were off for long extended times. The staff was inserviced by the DON on using the Interact Process and what to do if they were unable to reach the physician. Staff who had not completed the in-service will not work until the in-service has been completed. The Unit Manager on hall one, who is present at the start of each shift, will ensure no one works until they have been in-serviced. The Unit Manager on hall one begins each shift by providing education on the completion of appropriate nursing assessments.</p> <p>Review of the in-service that was provided to the DON on 12/19/13 by the Regional Nurse Consultant revealed it included IV insertion, emergency oxygen, and airway obstruction. The Unit Manager on hall one will ensure staff who have not completed the in-service will not work until in-serviced. Further review revealed all staff had been inserviced. Skills checks were also completed with staff related to IV insertion, emergency oxygen and airway obstruction. All</p>	F 157			

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F 157	<p>Continued From page 17</p> <p>staff scheduled to work after 7:00 PM Sunday had completed the skills check off.</p> <p>Interviews with LPN #1, LPN #2, LPN #3, LPN #4, LPN #5, RN #3 and RN #4 on 12/20/13 at 1:50 PM, 3:35 PM, 3:45 PM, and 4:10 PM, revealed they had been in-serviced related to residents' change in conditions, timely notification of the physician and/or the Medical Director, or to call 911 in an emergency. In addition, the staff revealed they were in-serviced on the Interact Process, accurate chart documentation, IV techniques and oxygen administration in an emergency.</p> <p>Interview with the DON, on 12/20/13 at 3:30 PM, revealed she was re-educated on 12/14/13 by the Regional Nurse Consultant which included educating the nurses to ensure they were comfortable with doing their job and completing their skills. In-services included education on documentation, emergency procedures, oxygen administration, physician notification, the Interact Process, and SBAR. The nurses were also strongly encouraged to not let these guidelines override their nursing judgement. The DON stated she will be more involved with nurses so she can identify their skill needs, and what education they may need. She stated the staff was instructed on timely notification, the Interact System, how to treat emergencies as emergencies and to err on the side of caution. The facility's expectation is for physician orders to be implemented and residents be sent out of the facility, if needed. Orders should be done timely and staff should be proactive and prevent emergencies instead of trying to hustle to get a resident out to the hospital. The assessment process should prevent those emergencies from</p>	F 157			

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F 157	Continued From page 18 happening. She stated she assisted the Assistant Director of Nursing and the Unit Manager and assessed all residents to ensure all needs were being met. Vital signs and visual assessments were completed, the information was documented, the charts were reviewed and compared with the care plans. All care plans were updated to ensure the residents' needs were being met. The Process now is to have a daily clinical meeting which includes (DON, ADON, and UM) to review new orders, care plans, and resident conditions. If needed, they will have an afternoon meeting to review anything that needed to be followed up on from the morning meeting. Any resident who had a significant change in the past thirty (30) days without physician notification had immediate physician notification. Further interview revealed medical records were reviewed on all residents for the last thirty (30) days beginning 12/14/13. All licensed staff was re-educated on the immediate notification of the physician with a sudden change in condition using the Interact Process, as a guide. If staff was unable to reach the physician, they may call the Medical Director. If the Medical Director doesn't answer within ten to fifteen minutes to send the resident out to the hospital. The Regional Nurse Consultant provided education to her and the acting ADON/UM for hall one. Education included the procedure for picking an IV site and insertion of the IV, follow up assessments every shift, signs and symptoms of infection, notification of the physician and documentation. Oxygen administration which included when to assess and apply, what to start the oxygen at, stay with the resident and to notify the physician to get a order. Competency validation with no staff working after 12/19/13 without having the	F 157			

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F 157	<p>Continued From page 19</p> <p>education and the validated competency. A Quality Assurance meeting was held on 12/14/13, they discussed the concerns and issues with the Medical Director and began making plans of correction that included in-services and education, assessments of residents, updated care plans and significant changes that the physician would need to be notified about. She stated they were monitoring for corrective actions and it was her responsibility to monitor the Twenty Four Hour Reports daily and to call the facility three (3) times a day on each shift to speak with the nurses and get a report on their residents. She stated she reviewed orders and care plans daily in the clinical meeting and she was auditing all admissions. Further interview revealed she would audit five records daily right now to ensure everything was in place then will audit weekly. Monitoring was reviewed by the Quality Assurance team.</p> <p>Interview with the Administrator, on 12/20/13 at 4:10 PM, revealed he was re-educated by the Regional Director Officer on 12/14/13. His education included understanding administrative duties, federal regulations, supervision of the Director of Nursing and other direct reports. They also reviewed their method and frequency of system monitoring. He stated he educated the Director of Nursing which included supervision of nursing staff on guidance and direction for all nurses. The education also included information to follow up with and communicate with nursing staff. He reviewed the DON's administrative duties, supervision of direct reports and method and frequency of system monitoring. He stated he was involved in the Quality Assurance meeting on 12/14/13 with the IDT members and the Medical Director via a conference call. Further interview</p>	F 157			

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F 157	Continued From page 20 revealed he reviewed all findings of the Immediate Jeopardy survey and the abatement. He stated he was overseeing audits, twenty four hour reports, physician orders review and daily shift reviews for significant changes in conditions. He stated he is also speaking with all new nurses within thirty (30) days of hire; and, a total of five nurses per month for three months to ensure their training needs were being met and communication with the DON was open and appropriate.	F 157	F281 1. Resident # 1 was discharged from the facility on 11-30-2013.  2. On 12-18-2013 the Director of Nursing and Unit Manager for hall I reviewed all residents' physician orders to assure that physician orders were being followed, any identified concerns were immediately corrected.		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on interview and review of the resident's record, Minimum Data Set (MDS) assessment, physician orders, nursing and Interdisciplinary Team notes, Ambulance Run Report, hospital's Emergency Department Physician's Chart, Kentucky Board of Nursing (KBN) Advisory Opinion, KBN Intravenous Therapy Course Content, and KBN Licensure Validation it was determined the facility failed to provide services that met professional standards of quality for one (1) of five (5) sampled residents (Resident #1). The facility failed to ensure Registered Nurse (RN) #1 was able to provide care within her scope of practice related to initiating physician ordered intravenous fluids (IVF) on 11/30/13 at 6:00 AM, for Resident #1 due to a significant change in condition (diarrhea, not drinking and not easily aroused).	F 281	3. The Regional Nurse Consultant re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for units one and two on notification of the physician if the nurse was unable to follow MD orders in a timely manner. On 12/14/2013 the Regional Nurse Consultant provided education to the Director of Nursing and the Unit Manager for hall one related to skill procedures for IV insertion, emergency oxygen administration, and airway obstruction with competency testing. The Director of Nursing or Unit Manager for hall one will provide training to all licensed nurses on IV insertion, emergency oxygen administration and airway obstruction with competency testing. No staff will work after 12/19/2013 without having received this education and validation competency.		

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420
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F 281	<p>Continued From page 21</p> <p>On 11/30/13 at approximately 5:00 AM, a Certified Nurse Aide (CNA) reported to RN #1 that Resident #1 was having diarrhea, did not want to drink and would not arouse easily. RN #1 assessed the resident and called the physician and left a message at approximately 5:30-6:00 AM. RN #1 received a return call from the physician at 6:00 AM with orders received for a Complete Blood Count (CBC), Comprehensive Metabolic Profile (CMP), Urinalysis (UA), chest x-ray, Intravenous Fluids (IV) Normal Saline at 90 cubic centimeters (cc) per hour (hr), and IV Flagyl (antibiotic) 500 milligrams (mg) three times a day (TID). RN #1 failed to provide the IV therapy which was in an RN's scope of practice and failed to notify the physician she was unable to initiate the IV. Licensed Practical Nurse (LPN) #1 (day shift nurse) went to the resident's room at 7:30 AM to carry out the physician's orders. She noted Resident #1 was having difficulty breathing, the resident's feet, knees and hands were mottled and Resident #1 was not responding. LPN #1 initiated oxygen (O2) at two (2) liters and performed an in and out catheterization to obtain urine for the UA. The resident's blood pressure (B/P) was 55/24 (normal range:120/70) and O2 saturation was 81% (normal range:98-100%). Resident #1 was mouth breathing, pulse was 47; respirations were 24; and, temperature was 97.1 degrees Fahrenheit. LPN #2 initiated the IV in the resident's right arm and started Normal Saline at 90 cc's an hour. The physician was called and the resident was sent to the emergency room at approximately 8:00 AM for evaluation. The Paramedic's initial assessment at the facility at 8:30 AM revealed Resident #1's IV fluids were not infusing. The resident was transferred to the hospital and diagnosed with Respiratory Failure,</p>	F 281	<p>4. The Director of Nursing, Unit Manager for Hall one or Hall two will review five (5) resident records per week to assure all physician orders were followed timely. All monitoring will be reviewed weekly by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Social Services Director Unit Managers for hall one and two, Dietary Service Manager with the Medical Director attending at least Quarterly.</p>	01/24/14
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F 281	<p>Continued From page 22</p> <p>Dehydration, Hypotension and Gastrointestinal Bleeding per rectum. The resident was admitted to the Intensive Care Unit and passed away at 4:42 PM.</p> <p>The facility's failure to ensure RN #1 provided care within her scope of practice related to initiating physician ordered IV therapy has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 12/13/13, and was determined to exist on 11/30/13. The facility was notified of the Immediate Jeopardy on 12/13/13. An acceptable Allegation of Compliance (AoC) was received on 12/19/13 and the State Survey Agency validated the Immediate Jeopardy was removed on 12/20/13, as alleged. A partial extended survey was conducted on 12/20/13. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the KBN Advisory Opinion Statement, last revised 10/2010, revealed KRS 314.011(G) defines "registered nursing practice" as the performance of acts requiring substantial specialized knowledge, judgement and nursing skills based upon principles of psychological, biological, physical and social sciences in application of the nursing process to include the administration and treatment as prescribed by the physician. Components include but are not limited to: Preparing and giving medication in the prescribed dosage, route and frequency.</p>	F 281			

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F 281	<p>Continued From page 23</p> <p>Review of KBN Recommended Course Content for IV Therapy for Registered Nurses and Licensed Practical Nurses, last revised 02/2010, revealed the nurses should be able to initiate, maintain, monitor and/or discontinue IV therapy. This includes: accurately interpreting medical orders for IV therapy, selecting the appropriate sites and infusion devices, assembling and setting up of IV solutions with tubings and needles, correctly and aseptically start a peripheral IV infusion, calculate flow rate correctly, use IV equipment including infusion pumps and mechanical controllers and patient controlled administration systems, and discontinue IV therapy safely.</p> <p>Review of the KBN Licensure Validation, dated 06/28/13, revealed RN#1 had been licensed to practice as an RN for approximately six (6) months at the time of the incident. RN #1's RN License was issued on 06/03/13 and the facility hired her on 07/09/13.</p> <p>Record review revealed the facility admitted Resident #1 on 12/31/08 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension (HTN) Not Other Specified (NOS), Chronic Ischemic Heart Disease, Senile Dementia Uncomplicated, Depressive Disorder NEC, Anemia NOS, Urinary Incontinence NOS, Tuberculosis (TB) of Bronchus, unspecified. Review of the MDS assessment, dated 10/07/13, revealed the facility had assessed Resident #1's cognition as severely impaired. Review of the physician orders, dated 11/01/13 through 11/30/13, revealed Resident #1 was a full code.</p> <p>Review of a telephone physician order, dated 11/30/13 at 6:00 AM, revealed an order for a</p>	F 281			

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F 281	<p>Continued From page 24</p> <p>Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), and Urinalysis (UA) now, chest x-ray, Normal Saline IV at 90 cc's per hour and Flagyl (antibiotic) 500 mg IV three times a day.</p> <p>Interview with RN #1, on 12/10/13 at 12:42 PM, 12/13/13 at 7:38 AM, and on 01/20/14 at 6:00 PM revealed CNA #1 had reported Resident #1 was having diarrhea and not wanting to take fluids. RN #1 stated around 5:00 AM she assessed and checked Resident #1's vital signs and the resident's blood pressure was "eighty something over fifty something". RN #1 stated she contacted the on-call physician and left a message between 5:30 AM and 6:00 AM and then started the morning medication pass. The RN stated at approximately 6:00 AM, the physician called with orders for labs, an x-ray, IV fluids, and medications. Further interview revealed she did not start the IV because Resident #1 was dehydrated and she did not have a lot of experience with starting an IV on someone that was dehydrated. She stated another reason she did not start the IV was because she did not have good feeling in her fingertips. She stated she had problems with starting IVs in nursing school because of not having good feeling in fingertips as she would have problems locating the vein with her fingers so the nursing instructor would have to help her. RN #1 stated she had started IVs in the facility before but every time she started an IV she always had another nurse with her. The RN stated she asked RN #2 for help a few different times during her shift, but she couldn't help her because she was having problems with her residents and she was in the middle of her medication pass. RN #1 stated everything was</p>	F 281			

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F 281	<p>Continued From page 25</p> <p>happening around 5:00 AM and 5:30 AM and she was overwhelmed. She stated after she received the physician's order at 6:00 AM, she called the Director of Nursing (DON), who was on call to let her know what was going on. She stated she knew the day shift nurse would be coming on and told the DON she would ask for help with the IV when the nurse got there. RN #1 revealed there was a pharmacy IV team but they were only supposed to call them when there were no other alternative's. She stated she continued to work on passing her medications. Further interview revealed when she saw LPN #2 come in she flagged her down and told her she needed help to start an IV. The RN stated LPN #2 clocked in and started the IV.</p> <p>Interview with the DON, on 12/11/13 at 2:15 PM, on 12/12/13 at 5:15 PM, on 12/13/13 at 3:05 PM, and on 01/16/14 at 10:30 AM revealed RN #1 had only been a nurse for approximately six (6) to eight (8) months. She stated RN #1 had orientation on the floor but the facility had provided no training or skills check offs to ensure the licensed staff was comfortable with and able to initiate IVs. The DON stated it was in the RN's scope of practice to start an IV and RN #1 had started IVs in the facility. The DON revealed the RN was only in charge of her hall and should have initiated the IV immediately. She stated if RN #1 was unable to start the IV, the RN could have asked RN #2 to assist, called the IV Team or sent Resident #1 to the hospital. Further interview revealed she was not sure if RN #1 asked for assistance to start the IV. She stated she received a call from RN #1 at 6:30 AM with an update about transfers and the RN had told her Resident #1 wasn't doing well. The DON stated she did not ask RN #1 if she needed help</p>	F 281			

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F 281	<p>Continued From page 26</p> <p>and if she had sounded like she needed help the DON would have asked RN #1 what was going on and what she needed.</p> <p>Interview with LPN #2, on 12/10/13 at 11:47 AM, on 12/12/13 at 4:50 PM, and on 01/21/14 at 3:08 PM revealed she was asked by RN #1 to start Resident #1's IV because RN #1 didn't think she could start it since Resident #1 was dehydrated. She stated she gathered the supplies and started Resident #1's IV around 7:00 AM. LPN #2 stated Resident #1 did not look good, his/her eyes were sunken and he/she looked dehydrated. LPN #2 stated she had witnessed RN #1 attempt to start an IV on another resident when she first started working at the facility and the resident's vein blew so she started the IV.</p> <p>Interview with LPN #1, on 12/10/13 at 10:30 AM, and on 12/12/13 at 4:10 PM, revealed she arrived at work at shift change and was told by RN #1 that Resident #1 wasn't doing well. The LPN revealed she could see that RN #1 was really overwhelmed and behind so she started helping. She stated when she entered Resident #1's room, the resident was pale, would not respond to staff, but would moan when touched. The LPN stated she checked the resident's vital signs and they were abnormal. The B/P was "like 55 over something". She stated she noted Resident #1 had mottling and the physician was called to get an order to send Resident #1 to the hospital at approximately 7:30 AM. She stated she got the order around 8:00 AM or 8:15 AM to send Resident #1 to the hospital.</p> <p>Review of the Nurse's Notes and Interdisciplinary Team Notes, dated 11/20/13 at 1:13 PM, revealed at 7:30 AM, LPN #1 (day shift nurse) entered the</p>	F 281			

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F 281	<p>Continued From page 27</p> <p>resident's room and noted Resident #1 was having difficulty breathing, the resident's feet, knees and hands were mottled, and the resident was not responding. The resident's blood pressure (B/P) was 55/24, O2 saturation was 81% before O2 was started; and, the resident was mouth breathing. The resident's pulse was 47, respirations 24, and temperature was 97.1 degrees Fahrenheit. LPN #2 initiated IV therapy for the resident per physician's order. The physician was called and advised of Resident #1's condition and code status. The Physician stated to send Resident #1 to the emergency room for evaluation.</p> <p>Review of the Ambulance Service Run Report and narrative, dated 11/30/13, revealed the Paramedic's initial assessment at the facility at 8:30 AM revealed Resident #1 was unresponsive, cold and pale and the IV fluids were not infusing.</p> <p>Review of the hospital Emergency Department Physician's Chart, dated 11/30/13, revealed Resident #1 was diagnosed with Respiratory Failure, Dehydration, Hypotension and Gastrointestinal Bleeding, per rectum. Interview with the Hospital Social Worker, on 12/10/13 at 9:03 AM, revealed the resident was admitted to the Intensive Care Unit and passed away at 4:42 PM.</p> <p>Interview with the Administrator, on 12/13/13 at 3:25 PM, revealed he expected the DON to make sure the nurses were ok. He stated the nurses working both third shift and day shift were working together to attend to the residents. He stated there was no distress in the conversation that was made to him around 8:00 AM or 8:30 AM and the nurses were handling everything very</p>	F 281			

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F 281	<p>Continued From page 28</p> <p>well. He stated he felt like the nurses had used good judgement up to and including sending Resident #1 to the hospital. The Administrator stated the DON and the nurses had everything under control. He stated there was no distress or concern on the nurses' part, who relayed the situation to the DON.</p> <p><b>**The facility implemented the following actions to remove the Immediate Jeopardy:</b></p> <p>On 12/14/13, the Regional Director of Operations re-educated the Administrator related to the responsibility of the Administrator to oversee the facility in accordance with Federal regulations to include monitoring of the Director of Nursing related to the supervision of nursing staff. On 12/14/13, the Administrator re-educated the Director of Nursing on the requirements to supervise nursing staff to include guidance and direction for new nurses as well as follow up questions in communications with the nursing staff. On 12/14/13, the Regional Nurse Consultant re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for hall one and two on the Interact Process, timely notification of the physician and using the Medical Director if unable to reach the attending physician timely including calling 911 in an emergency situation. The Interact Process is an evidence based practice program developed at the request of the Centers for Medicaid and Medicare Services to reduce unnecessary return hospitalizations. The Regional Nurse Consultant also re-educated the Director of Nursing, Assistant Director of Nursing and Unit Managers for units one and two on notification of the physician if the nurse was unable to follow MD</p>	F 281			

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F 281	<p>Continued From page 29</p> <p>orders in a timely manner. It includes suggestions for nurses on when to notify the physician and what recommendations for treatments to make, but does not override the judgement of the nurse at bedside.</p> <p>Resident #1 was discharged from the facility on 11/30/13. All Current residents of the facility have been reviewed by the Interdisciplinary Team (IDT) to include the Director of Nursing, Unit Managers for halls one and two, Assistant Director of Nursing, MDS Coordinator and Social Services Director, to assure that any current resident who is experiencing a significant change in condition had physician notification. Any resident who was deemed to have had a significant change in condition in the past thirty (30) days without physician notification had immediate physician notification. This review included a set of vital signs and visual examination of the resident for apparent acute distress by the Director of Nursing, Assistant Director of Nursing or Unit Managers; and, a review of the medical record for the past thirty (30) days by the IDT. This was completed on 12/14/13.</p> <p>The IDT, which included the Director of Nursing, Unit Managers, MDS Coordinator and Social Services Director, reviewed all current residents' care plans on 12/14/13 to assure that the care plan was up to date and met the needs of the resident, and that the care plan interventions were in place. Any resident whose care plan was not up to date to meet the needs of the resident had the care plan updated. Any interventions not in place were implemented.</p> <p>Beginning 12/14/13, all licensed staff was re-educated on immediate notification of the</p>	F 281			

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F 281	<p>Continued From page 30</p> <p>physician with a significant change in condition using the Interact Process as a guideline, but not to supercede the judgement of the nurse in attendance. In addition, the education included notification of the Medical Director if they were unable to reach the attending physician timely. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this education.</p> <p>Beginning on 12/14/13, all licensed staff was re-educated on the completion of appropriate nursing assessments with follow up based upon the resident's condition with examples of abnormal vital signs, respiratory and gastro-intestinal using the Interact guidelines and pathways as a guide, not to supercede the judgement of the nurses in attendance. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall number one. No licensed staff will work after 12/14/13 without having received this re-education.</p> <p>On 12/14/13, the Regional Nurse Consultant will provide education to the Director of Nursing and the Unit Manager for hall one related to skill procedures for IV insertion, emergency oxygen administration, and airway obstruction with competency testing. The Director of Nursing or Unit Manager for hall one will provide training to all licensed nurses on IV insertion, emergency oxygen administration and airway obstruction with competency testing. No staff will work after 12/19/13, without having received this education and validation competency.</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER  HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 281	<p>Continued From page 31</p> <p>An Ad Hoc Quality Assurance Committee meeting (QPI) was held on 12/14/13 to review the alleged deficient practice as well as the plan for removal to include audits for care plans and care plan interventions to assure care plans meet the needs of the residents and interventions are followed, and all training material presented to licensed staff. The discussion also included training completed for the Administrator and the Director of Nursing and how the facility will monitor corrective actions. In attendance was the Administrator, the Director of Nursing, the Assistant Director of Nursing, Unit Manager, MDS Nurse and the Social Service Director. The Medical Director attended via conference call. No further recommendations were made by the committee. The Quality Assurance Committee will meet weekly to review the removal plan as well as monitoring of actions weekly until substantial compliance is achieved.</p> <p>Monitoring of the allegation of compliance will be conducted by doing the following: The Director of Nursing or Unit Manager for hall one will review the Twenty Four Hour Report and all physician orders daily for two weeks, followed by five times a week for at least ten weeks to assure all changes in condition had appropriate physician notification, assessment and follow up. In addition, the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall one will contact the facility once each shift to review with each nurse any significant changes in resident condition to assure licensed staff are assessing and notifying the physician timely. This will occur daily for two weeks, followed by five times per week for at least ten weeks on each shift. The Administrator will speak with all new nurses within the first thirty (30) days of</p>	F 281			

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F 281	<p>Continued From page 32</p> <p>employment and at least five nurses per month for three months to assure training needs are met as well as to assure communication with the Director of Nursing is open and appropriate. The Director of Nursing will audit five resident records per week for twelve weeks to ensure that the care plans meet the needs of the resident and care plan interventions are followed.</p> <p>All monitoring will be received weekly by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Social Services Director, Unit Managers for hall one and two, the Dietary Services Manager and the Medical Director attending at least quarterly. Failure to comply with any of the above will result in individual re-training and as appropriate disciplinary action. The Center alleges by the above actions that the Immediate Jeopardy was abated for all residents on 12/20/13.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Review of an in-service provided to the Administrator on 12/14/13 revealed the Administrator was Inserviced on the Administration, Supervision and monitoring of system implementation to understand administrative duties and Federal regulations. The supervision of the DON and other direct reports and the method and frequency of system monitoring.</p>	F 281			

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F 281	<p>Continued From page 33</p> <p>Review of an in-service provided to nursing staff on 12/14/13 revealed it included physician notification regarding a resident change in condition, completion of appropriate nursing assessments and follow up, Interact Process review, notification of the physician, call the Medical Director if unable to reach the attending physician timely and to call 911 in an emergency, with no need to call the physician first.</p> <p>Review of the Regional Director Officer's education of the Administrator revealed the Administrator was educated on 12/14/13 related to monitoring the DON's supervision of the nursing staff to include guidance and direction for new nurses and follow up communication.</p> <p>Review of the Regional Nurse Consultant's re-education of the DON, ADON and Unit Managers for halls one and two on 12/14/13 revealed it included: the Interact Process, timely notification, using the Medical Director, and calling 911 if unable to follow physician orders.</p> <p>Review of all residents' assessments performed on 12/14/13 revealed an assessment was conducted which included vital signs and visual examinations. Physician notification was completed if needed for a change in condition by the DON, ADON and Unit Managers. The results were reviewed by the IDT.</p> <p>Review of inservices conducted on 12/14/13 revealed all staff received the inservices, except for two staff who were off for long extended times. The staff was inserviced by the DON on using the Interact Process and what to do if they were unable to reach the physician. Staff who</p>	F 281			

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F 281	<p>Continued From page 34</p> <p>had not completed the in-service will not work until the in-service has been completed. The Unit Manager on hall one, who is present at the start of each shift, will ensure no one works until they have been in-serviced. The Unit Manager on hall one begins each shift by providing education on the completion of appropriate nursing assessments.</p> <p>Review of the in-service that was provided to the DON on 12/19/13 by the Regional Nurse Consultant revealed it included IV insertion, emergency oxygen, and airway obstruction. The Unit Manager on hall one will ensure staff who have not completed the in-service will not work until in-serviced. Further review revealed all staff had been in-serviced. Skills checks were also completed with staff related to IV insertion, emergency oxygen and airway obstruction. All staff scheduled to work after 7:00 PM Sunday had completed the skills check off.</p> <p>Interviews with LPN #1, LPN #2, LPN #3, LPN #4, LPN #5, RN #3 and RN #4 on 12/20/13 at 1:50 PM, 3:35 PM, 3:45 PM, and 4:10 PM revealed they had been in-serviced related to residents' change in conditions, timely notification of the physician and/or the Medical Director, or to call 911 in an emergency. In addition, the staff revealed they were in-serviced on the Interact Process, accurate chart documentation, IV techniques and oxygen administration in an emergency.</p> <p>Interview with the DON on 12/20/13 at 3:30 PM, revealed she was re-educated on 12/14/13 by the Regional Nurse Consultant which included educating the nurses to ensure they were comfortable with doing their job and completing</p>	F 281			

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F 281	Continued From page 35 their skills. In-services included education on documentation, emergency procedures, oxygen administration, physician notification, the Interact Process, and SBAR. The nurses were also strongly encouraged to not let these guidelines override their nursing judgement. The DON stated she will be more involved with nurses so she can identify their skill needs, and what education they may need. She stated the staff was instructed on timely notification, the Interact System, how to treat emergencies as emergencies and to err on the side of caution. The facility's expectation is for physician orders to be implemented and residents be sent out of the facility, if needed. Orders should be done timely and staff should be proactive and prevent emergencies instead of trying to hustle to get a resident out to the hospital. The assessment process should prevent those emergencies from happening. She stated she assisted the Assistant Director of Nursing and the Unit Manager and assessed all residents to ensure all needs were being met. Vital signs and visual assessments were completed, the information was documented, the charts were reviewed and compared with the care plans. All care plans were updated to ensure the residents' needs were being met. The Process now is to have a daily clinical meeting which includes (DON, ADON, and UM) to review new orders, care plans, and resident conditions. If needed, they will have an afternoon meeting to review anything that needed to be followed up on from the morning meeting. Any resident who had a significant change in the past thirty (30) days without physician notification had immediate physician notification. Further interview revealed medical records were reviewed on all residents for the last thirty (30) days beginning 12/14/13.	F 281			

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F 281	<p>Continued From page 36</p> <p>All licensed staff was re-educated on the immediate notification of the physician with a sudden change in condition using the Interact Process, as a guide. If staff was unable to reach the physician, they may call the Medical Director. If the Medical Director doesn't answer within ten to fifteen minutes to send the resident out to the hospital. The Regional Nurse Consultant provided education to her and the acting ADON/UM for half one. Education included the procedure for picking an IV site and insertion of the IV, follow up assessments every shift, signs and symptoms of infection, notification of the physician and documentation. Oxygen administration which included when to assess and apply, what to start the oxygen at, stay with the resident and to notify the physician to get a order. Competency validation with no staff working after 12/19/13 without having the education and the validated competency. A Quality Assurance meeting was held on 12/14/13, they discussed the concerns and issues with the Medical Director and began making plans of correction that included in-services and education, assessments of residents, updated care plans and significant changes that the physician would need to be notified about. She stated they were monitoring for corrective actions and it was her responsibility to monitor the Twenty Four Hour Reports daily and to call the facility three (3) times a day on each shift to speak with the nurses and get a report on their residents. She stated she reviewed orders and care plans daily in the clinical meeting and she was auditing all admissions. Further interview revealed she would audit five records daily right now to ensure everything was in place then will audit weekly. Monitoring was reviewed by the Quality Assurance team.</p>	F 281			

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F 281	Continued From page 37  Interview with the Administrator on 12/20/13 at 4:10 PM, revealed he was re-educated by the Regional Director Officer on 12/14/13. His education included understanding administrative duties, federal regulations, supervision of the Director of Nursing and other direct reports. They also reviewed their method and frequency of system monitoring. He stated he educated the Director of Nursing which included supervision of nursing staff on guidance and direction for all nurses. The education also included information to follow up with and communicate with nursing staff. He reviewed the DON's administrative duties, supervision of direct reports and method and frequency of system monitoring. He stated he was involved in the Quality Assurance meeting on 12/14/13 with the IDT members and the Medical Director via a conference call. Further interview revealed he reviewed all findings of the Immediate Jeopardy survey and the abatement. He stated he was overseeing audits, twenty four hour reports, physician orders review and dally shift reviews for significant changes in conditions. He stated he is also speaking with all new nurses within thirty (30) days of hire; and, a total of five nurses per month for three months to ensure their training needs were being met and communication with the DON was open and appropriate.	F 281	F282  1. Resident # 1 was discharged from the facility on 11-30-2013. 2. The IDT, which included the Director of Nursing, Unit Managers for halls one and two and the MDS Coordinator and Social Services Director, reviewed all current residents' care plans on 12/14/2013 to assure that the care plan was up to date and met the needs of the resident, and the care plan interventions were in place. Any resident whose care plan was not up to date to meet the needs of the resident had the care plan updated. Any interventions not in place were implemented. 3. Beginning 12/14/2013, all licensed staff was re-educated on the immediate notification of the physician with a significant change in condition using the Interact Process as a guideline, but not to supersede the judgment of the judgment of the nurse in attendance. In addition, the education included notification of the Medical Director if they were unable to reach the attending physician timely. This re-education was completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for hall one. No licensed staff will work after 12/14/13 without having received this education. Beginning 12/14/2013, all licensed staff was re-educated on the completion of appropriate nursing assessments with follow up based upon the resident's condition with examples of abnormal vital signs, respiratory and		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282			