PRINTED: 04/20/2015
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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
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| | 185401 | | R-C 04/17/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EDMONSON CENTER | 813 S. MAIN ST. BROWNSVILLE, KY 42210 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| {F 000} | INITIAL COMMENTS<br><br>A Revisit Survey to the 12/19/15 Abbreviated Survey was conducted on 04/15/15 through 04/17/15 in conjunction with an Abbreviated Survey (KY #23042) and determined the facility was in compliance on 03/25/15 as alleged. KY #23042 was unsubstantiated with no regulatory violations. | {F 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

RECEIVED APR 2015 OFFICE OF INSPECTOR GENERAL

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

PRINTED: 03/25/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| | 185401 | | R-C 03/11/2015 |

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| {F 000} | INITIAL COMMENTS<br><br>A Revisit Survey to the 12/19/14 Abbreviated Survey (KY#22525 and KY#22552) was conducted on 03/10/15 through 03/11/15. Deficient practice at 42 CFR 483.25 Quality of Care at F309 and F323 was determined to be corrected. However, continued non-compliance was identified at 42 CFR 483.20 Resident Assessment at F281 and F282 and 42 CFR 483.75 Administration at F490 and F520 with an additional deficiency cited at 42 CFR 483.25 Quality of Care at F328 at a scope and severity of a "D". | {F 000} | "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Edmonson Center** does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." | |
| {F 281} SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of facility policy and the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14, it was determined the facility failed to ensure Physician's Orders were implemented for oxygen therapy for one (1) of ten (10) sampled residents (Resident #13). Resident #13 was observed on 03/11/15 at 3:55 PM with oxygen being administered at five (5) Liters (L) per minute; however, review of the Physician's Order revealed the resident's oxygen should have been administered at 2.5/L. Review of the Treatment Administration Record (TAR) revealed the oxygen administration amount was not documented on the TAR to ensure staff was checking every shift to ensure the ordered amount of oxygen was | {F 281} | F 281<br>Step 1<br>A Registered Nurse assessed resident #13 on 3/10/2015 and the Nurse Practitioner re-assessed resident #13 on 3/11/15. Resident was found to have no change of condition associated with increased oxygen use. Re-education was provided to Resident #13 and spouse on the importance of not adjusting oxygen flow rate on 3/11/15 by an R.N. The Nurse Practitioner provided a clarification order for oxygen use for Resident #13 on 3/12/15. A Registered Nurse updated Resident #13's care plan on 3/10/15 to include specific oxygen orders. Resident #13's Treatment Administration Record (TAR) was updated on 3/10/15 by an R.N. to include monitoring of the rate and route of oxygen administration per physician order. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Swihart — TITLE: Administrator — (X6) DATE: 4/7/15

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 281} | Continued From page 1 being administered.<br><br>The findings include:<br><br>Review of the Kentucky Board of Nursing AOS #14, "Patient Care Orders", last revised 10/2010, revealed nurses are individually responsible and accountable for rendering safe, effective nursing care to clients and for judgments exercised and actions taken in the course of providing care. Further review revealed licensed nurses are responsible for the administration of medications and treatments as prescribed by the physician or advanced practical registered nurse.<br><br>Review of a facility policy titled, "Oxygen", last revised 12/08/14, revealed "Set liter flow per order".<br><br>Record review revealed the facility readmitted Resident #13 on 02/04/15 after being discharged from an acute care hospital where he/she was treated for diagnoses to include Acute Hypercarbic and Hypoxic Respiratory Failure. Resident #13 had additional diagnoses to include Diabetes Mellitus, Obstructive Sleep Apnea and Dementia. Review of the significant change Minimum Data Set (MDS) assessment, dated 02/11/15, revealed the facility assessed Resident #13's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of ten (10) indicating the resident was interviewable. In addition, Resident #13 was assessed as requiring extensive assistance with all activities of daily living.<br><br>Review of Resident #13's Admission Physician's Orders, dated 02/04/15, revealed to administer oxygen at 2.5 liters (L). | {F 281} | Step 2<br>A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/11/15 through 3/12/15. This review compared Physician or Nurse Practitioner orders to the Treatment Administration Record to ensure both matched; corrective action completed as indicated. On these same dates, an R.N. then validated that the oxygen treatment was implemented per physician orders; corrective action completed as indicated.<br><br>A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/12/15 through 3/14/15 to ensure the resident care plan includes information regarding oxygen use; corrective action completed as indicated.<br><br>Step 3<br>On 3/12/2015, the Regional Manager of Clinical Operations provided in-person re-education to the Nurse Practice Educator and Director of Nursing. They were re-educated on the following information:<br><br>• Physician/N.P. order verification prior to initiating oxygen<br>• Facility policies/procedures for oxygen concentrator use<br>• Facility policies/procedures for high pressure cylinder use | |

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| {F 281} | Continued From page 2<br><br>Observation, on 03/11/15 at 3:55 PM, revealed Resident #13 was in bed with oxygen administered via nasal cannula and the oxygen concentrator was set at 5/L. Resident #13 stated she did not know what the oxygen concentrator was supposed to be on and did not know what it was set on.<br><br>Interview, on 03/11/15 at 3:56 PM with Licensed Practical Nurse (LPN) #4, revealed she was not aware what Resident #13's oxygen administration rate was and it was not documented on the resident's Treatment Administration Record (TAR). LPN #4 checked the Physician's Orders and verified the oxygen was to be administered at 2.5/L and not 5/L.<br><br>Review of the March 2015 TAR revealed there was no documented evidence the resident had an order for oxygen at 2.5 L. However, there was documented evidence staff was to conduct oxygen saturation checks every shift and change out the oxygen tubing weekly.<br><br>Interview with LPN #5, on 03/11/15 at 4:45 PM, revealed somehow the TAR that was generated from the orders that were put into the computer did not include the oxygen administration amount but did print the oxygen saturation checks every shift and the weekly oxygen tubing change.<br><br>Interview conducted with Registered Nurse (RN) #1, on 03/11/15 at 5:00 PM, revealed he verified Resident #13's orders on readmission on 02/04/15 and typed them into the computer. He stated the computer automatically prints the Medication Administration Records (MARs) and TARs from the orders that were entered into the | {F 281} | • Facility policies/procedures for physician order transcription<br>• Reviewed process for order entry in Point Click Care<br>• Provide care in accordance to each resident's plan of care<br><br>Between the dates of 3/12/15 through 3/20/15 Licensed Nurses received re-education provided by the Nurse Practice Educator or the Director of Nursing on the education noted above.<br><br>Licensed nurses completed a pre-test and a post-test to measure learning of the above re-education; this testing was provided by and graded by a Registered Nurse. Any Licensed staff that was unavailable during this period will be re-educated prior to returning to work.<br><br>Step 4<br>A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is noted on the Treatment Administration Record and provided at the prescribed liters per minute. A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is included on the resident's care plan and implemented in accordance with the residents plan of care. These audits will be | |

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| {F 281} | Continued From page 3<br>computer. RN #1 could not explain why the oxygen administration order was not printed on the resident's TAR. RN #1 revealed too much oxygen administration could cause a drop in Resident #13's respiratory drive causing a potential problem.<br><br>Interview conducted with the Director of Nursing (DON), on 03/11/15 at 4:30 PM, revealed she did not understand why Resident #13's oxygen administration order was not on the TAR and should have been. She stated the facility's procedure was for the flow rate to be on the resident's TAR and licensed staff would verify the rate each shift and initial the TAR. However, staff had failed to identify the oxygen rate was not on the TAR and the resident was receiving the incorrect rate of oxygen. | {F 281} | conducted five times a week for fourteen days, then three times per week for four weeks and then at least once weekly for an additional four weeks.<br><br>Audit results will be reviewed by the Performance Improvement Committee monthly for the next three months. The Performance Improvement consists of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, and Nutrition Services Director. Further audits will be determined by the Performance Improvement Committee based on audit results.<br><br>Completion Date: | 3/25/2015 |
| {F 282}<br>SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure services provided by the facility were in accordance with the written plan of care for one (1) of ten (10) sampled residents (Resident #13). Resident #13 was care planned for oxygen as ordered via nasal cannula; however, observation on 03/11/15 revealed the resident's oxygen was being administered at five | {F 282} | | |

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| {F 282} | Continued From page 4<br>(5) liters (L) instead of the physician ordered 2.5/L.<br><br>The findings include:<br><br>Review of facility policy titled, "Care Plans", last revised 01/02/14, revealed the comprehensive, individualized care plan should be developed by the interdisciplinary team for each resident. The care plan should include measurable objectives to meet resident needs and goals as identified by the assessment process. The purpose was to provide necessary care and services to attain or maintain the patient's highest practicable physical, mental and psychosocial well being.<br><br>Record review revealed Resident #13 was readmitted to the facility on 02/04/15 after being discharged from an acute care hospital with diagnoses which included Acute Hypercarbic, Hypoxic Respiratory Failure, Diabetes Mellitus, Obstructive Sleep Apnea and Dementia. Review of the significant change Minimum Data Set (MDS) assessment, dated 02/11/15, revealed the facility assessed Resident #13's cognition as interviewable with a Brief Interview of Mental Status (BIMS) score of ten (10) which indicated the resident was interviewable. In addition, the resident required extensive assistance with all activities of daily living.<br><br>Review of Physician's Orders, dated 02/04/15, revealed for staff to administer oxygen at 2.5 L.<br><br>Review of Resident #13's Comprehensive Care Plan for "At risk for complications related to Congestive Obstructive Pulmonary Disease, Respiratory Abnormalities, Respiratory Failure and Obstructive Sleep Apnea", last revised | {F 282} | F 282<br><br>Step 1<br>A Registered Nurse assessed resident #13 on 3/10/2015 and the Nurse Practitioner re-assessed resident #13 on 3/11/15. Resident was found to have no change of condition associated with increased oxygen use. Re-education was provided to Resident #13 and spouse on the importance of not adjusting oxygen flow rate on 3/11/15 by an R.N. The Nurse Practitioner provided a clarification order for oxygen use for Resident #13 on 3/12/15. A Registered Nurse updated Resident #13's care plan on 3/10/15 to include specific oxygen orders. Resident #13's Treatment Administration Record (TAR) was updated on 3/10/15 by an R.N. to include monitoring of the rate and route of oxygen administration per physician order.<br><br>Step 2<br>A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/11/15 through 3/12/15. This review compared Physician or Nurse Practitioner orders to the Treatment Administration Record to ensure both matched; corrective action completed as indicated. On these same dates, an R.N. then validated that the oxygen treatment was implemented per physician orders; corrective action completed as indicated. | |

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| {F 282} | Continued From page 5<br>02/06/15, revealed an intervention to "administer oxygen as ordered via nasal cannula".<br><br>Observation, on 03/11/15 at 3:55 PM, revealed Resident #13 was in bed with oxygen being administered via nasal cannula and the oxygen concentrator was set at 5/L. Interview with Resident #13 at the time revealed she did not know what the oxygen concentrator was supposed to be on and did not know what it was set on.<br><br>Interview, on 03/11/15 at 3:56 PM with Licensed Practical Nurse (LPN) #4, revealed she was not aware what Resident #13's oxygen administration rate was and it was not documented on the resident's Treatment Administration Record . LPN #4 checked the Physician's Orders and verified the oxygen was to be administered at 2.5/L and not 5/L.<br><br>Interview with Registered Nurse (RN) #1, on 03/11/15 at 5:00 PM, revealed Resident #13 was to have oxygen administered at 2.5/L. RN #1 stated the resident's plan of care was not being followed if the administration of the oxygen was at 5/L and not 2.5 as ordered and the resident was at risk for a drop in respiratory drive which could be a potential problem. RN #1 revealed it was the licensed staffs' responsibility to ensure care plan interventions were implemented correctly.<br><br>A post survey interview on 03/16/15 at 1:00 PM with the Clinical Case Coordinator, revealed she was responsible for creating, reviewing and revising residents' plans of care. She stated she had reviewed and revised Resident #13's care plan for "At risk for complications related to Congestive Obstructive Pulmonary Disease, | {F 282} | A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/12/15 through 3/14/15 to ensure the resident care plan includes information regarding oxygen use; corrective action completed as indicated.<br><br>Step 3<br>On 3/12/2015, the Regional Manager of Clinical Operations provided in-person re-education to the Nurse Practice Educator and Director of Nursing. They were re-educated on the following information:<br><br>• Physician/N.P. order verification prior to initiating oxygen<br>• Facility policies/procedures for oxygen concentrator use<br>• Facility policies/procedures for high pressure cylinder use<br>• Facility policies/procedures for physician order transcription<br>• Reviewed process for order entry in Point Click Care<br>• Provide care in accordance to each resident's plan of care<br>Between the dates of 3/12/15 through 3/20/15 Licensed Nurses received re-education provided by the Nurse Practice Educator or the Director of Nursing on the education noted above. | |

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| (F 282) | Continued From page 6<br>Respiratory Abnormalities, Respiratory Failure and Obstructive Sleep Apnea" on 02/06/15 after the resident was readmitted from the hospital on 02/04/15. The Clinical Case Coordinator revealed she expected staff to follow the resident's care plan. She also stated "Ambassador" rounds were completed weekly by assigned staff to check residents' rooms, care plans, Certified Nurse Aide (CNA) sheets and Physician's Orders to make sure they did not miss anything. She stated she had completed the "Ambassador" rounds for Resident #13 and she had not identified any issues with the resident's oxygen.<br><br>Interview with the Director of Nursing (DON), on 03/11/15 at 4:30 PM, revealed the resident's care plan for oxygen administration was for "as ordered" and the care plan was not being followed and could have been problematic for Resident #13. | (F 282) | Licensed nurses completed a pre-test and a post-test to measure learning of the above re-education; this testing was provided by and graded by a Registered Nurse. Any Licensed staff that was unavailable during this period will be re-educated prior to returning to work.<br><br>Step 4<br>A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is noted on the Treatment Administration Record and provided at the prescribed liters per minute. A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is included on the resident's care plan and implemented in accordance with the residents plan of care. These audits will be conducted five times a week for fourteen days, then three times per week for four weeks and then at least once weekly for an additional four weeks. | |
| F 328<br>SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced | F 328 | Audit results will be reviewed by the Performance Improvement Committee monthly for the next three months. The Performance Improvement consists of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, and Nutrition Services Director. Further audits will be determined by the Performance Improvement Committee based on audit results.<br><br>Completion Date: | 3/25/2015 |

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| F 328 | Continued From page 7 by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure one (1) of ten (10) sampled residents (Resident #13), received the proper treatment and care for oxygen administration. Resident #13 was observed on 03/11/15 with oxygen being administered at five (5) Liters (L) per nasal cannula instead of the physician ordered 2.5/L.<br><br>The findings include:<br><br>Review of a facility policy titled, "Oxygen", last revised 12/08/14, revealed "Set liter flow per order".<br><br>Record review revealed the facility readmitted Resident #13 on 02/04/15 after being discharged from an acute care hospital where he/she was treated for Acute Hypercarbic and Hypoxic Respiratory Failure. Resident #13 had additional diagnoses to include Diabetes Mellitus, Obstructive Sleep Apnea, and Dementia. Review of the significant change Minimum Data Set (MDS) assessment, dated 02/11/15, revealed the facility assessed Resident #13 as interviewable with a Brief Interview of Mental Status score of ten (10). In addition, the facility assessed he/she required extensive assistance with all activities of daily living.<br><br>Observation and interview on 03/11/15 at 3:55 PM, revealed Resident #13 was in bed with oxygen being administered via nasal cannula and the oxygen concentrator was set at 5/L. Resident #13 stated she did not know what the oxygen concentrator was supposed to be on and did not know what it was set on. | F 328 | F 328<br><br>Step 1<br>A Registered Nurse assessed resident #13 on 3/10/2015 and the Nurse Practitioner re-assessed resident #13 on 3/11/15. Resident was found to have no change of condition associated with increased oxygen use. Re-education was provided to Resident #13 and spouse on the importance of not adjusting oxygen flow rate on 3/11/15 by an R.N. The Nurse Practitioner provided a clarification order for oxygen use for Resident #13 on 3/12/15. A Registered Nurse updated Resident #13's care plan on 3/10/15 to include specific oxygen orders. Resident #13's Treatment Administration Record (TAR) was updated on 3/10/15 by an R.N. to include monitoring of the rate and route of oxygen administration per physician order.<br><br>Step 2<br>A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/11/15 through 3/12/15. This review compared Physician or Nurse Practitioner orders to the Treatment Administration Record to ensure both matched; corrective action completed as indicated. On these same dates, an R.N. then validated that the oxygen treatment was implemented per physician orders; corrective action completed as indicated. | |

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| F 328 | Continued From page 8<br><br>Review of Resident #13's Physician Order, dated 02/04/15, revealed an order to administer oxygen at 2.5 L.; however, review of the March 2015 Treatment Administration Record (TAR) revealed there was no documented evidence the resident had an order to be administered oxygen at 2.5 L.<br><br>Review of Resident #13's Comprehensive Care Plan for at risk for complications related to Congestive Obstructive Pulmonary Disease, Respiratory Abnormalities, Respiratory Failure and Obstructive Sleep Apnea, last revised 02/06/15, revealed an intervention to "administer oxygen as ordered via nasal cannula".<br><br>Interview on 03/11/15 at 3:56 PM with Licensed Practical Nurse (LPN) #4 revealed she was not aware what Resident #13's oxygen administration rate was. LPN #4 checked the Physician's Orders and verified the oxygen was to administered at 2.5/L and not 5/L.<br><br>On 03/11/15 at 5:00 PM, an interview conducted with Registered Nurse (RN) #1, revealed on 02/04/15, RN #1 had verified Resident #13's orders from the hospital on readmission to the facility and typed them into the computer. RN #1 stated the computer should have automatically printed the TAR to include any oxygen administration orders. RN #1 could not explain why the oxygen administration had not printed on the resident's TAR, which was how licensed staff would check the oxygen administration rate and document to verify each shift. He also stated too much oxygen administration could cause a drop in Resident #13's respiratory drive causing a potential problem. | F 328 | A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/12/15 through 3/14/15 to ensure the resident care plan includes information regarding oxygen use; corrective action completed as indicated.<br><br>Step 3<br>On 3/12/2015, the Regional Manager of Clinical Operations provided in-person re-education to the Nurse Practice Educator and Director of Nursing. They were re-educated on the following information:<br><br>• Physician/N.P. order verification prior to initiating oxygen<br>• Facility policies/procedures for oxygen concentrator use<br>• Facility policies/procedures for high pressure cylinder use<br>• Facility policies/procedures for physician order transcription<br>• Reviewed process for order entry in Point Click Care<br>• Provide care in accordance to each resident's plan of care<br>Between the dates of 3/12/15 through 3/20/15 Licensed Nurses received re-education provided by the Nurse Practice Educator or the Director of Nursing on the education noted above. | |

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| F 328 | Continued From page 9<br>According to an interview with LPN #5, on 03/11/15 at 4:45 PM, the TAR that was generated from the orders that were typed into the computer did not include the oxygen administration amount but did print the oxygen saturation checks every shift and the weekly oxygen tubing change. She stated the TAR and MAR were checked against new orders daily in the morning meeting and the TAR information that did not print on Resident #13's TAR should have been identified on that check but was not.<br><br>Interview with the Director of Nursing (DON), conducted on 03/11/15 at 4:30 PM, revealed licensed staff were to verify the rate of oxygen administration for each resident receiving oxygen therapy and document that verification on the resident's TAR. The DON stated Resident #13's rate of administration of oxygen was not on the resident's TAR and should have been. The DON revealed she oversees the morning meeting and all admissions and new orders were reviewed to verify the orders to the TARs and MARs; however, they failed to identify Resident #13's oxygen order was not on the TAR. The DON stated a first of the month check of orders to MARs and TARs was also completed for March, but also failed to identify the oxygen administration was not placed on the TAR. | F 328 | Licensed nurses completed a pre-test and a post-test to measure learning of the above re-education; this testing was provided by and graded by a Registered Nurse. Any Licensed staff that was unavailable during this period will be re-educated prior to returning to work.<br><br>Step 4<br>A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is noted on the Treatment Administration Record and provided at the prescribed liters per minute. A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is included on the resident's care plan and implemented in accordance with the residents plan of care. These audits will be conducted five times a week for fourteen days, then three times per week for four weeks and then at least once weekly for an additional four weeks.<br><br>Audit results will be reviewed by the Performance Improvement Committee monthly for the next three months. The Performance Improvement consists of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, and Nutrition Services Director. Further audits will be determined by the Performance Improvement Committee based on audit results. | |
| {F 490}<br>SS=D | 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. | {F 490} | Completion Date: | 3/25/2015 |

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| {F 490} | Continued From page 10<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review and review of the facility's Administrator's Job Description, Administrator's Responsibilities, and the facility's Plan of Correction for the 12/19/14 survey it was determined the facility's Administration failed to ensure policy and procedures were implemented to prevent deficient practice from reoccurring for one (1) of ten (10) sampled residents (Resident #13). Resident #13 was observed on 03/11/15 with oxygen being administered at a rate of five (5) Liters (L) instead of the prescribed 2.5/L. Interview and record review revealed the resident's order for the oxygen should have been reviewed on 02/05/15 (the day after the resident was admitted) in the facility's morning meeting along with the resident's plan of care to ensure the correct rate of oxygen was being administered. However, this discrepancy had not been identified.<br><br>The findings include:<br><br>Review of the facility's policy titled "Administrator Responsibilities", last revised 04/01/03, revealed the Administrator will be responsible for the day to day operations of the Center in accordance with Corporate Policies and Procedures and State, Federal and local regulations.<br><br>Review of the Job Description for the Administrator, revised 08/01/12, revealed "The Administrator is responsible for planning and is accountable for all activities and departments of the Center subject to rules and regulations promulgated by government agencies to ensure | {F 490} | F 490<br><br>Step 1<br>A Registered Nurse assessed resident #13 on 3/10/2015 and the Nurse Practitioner re-assessed resident #13 on 3/11/15. Resident was found to have no change of condition associated with increased oxygen use. Re-education was provided to Resident #13 and spouse on the importance of not adjusting oxygen flow rate on 3/11/15 by an R.N. The Nurse Practitioner provided a clarification order for oxygen use for Resident #13 on 3/12/15. A Registered Nurse updated Resident #13's care plan on 3/10/15 to include specific oxygen orders. Resident #13's Treatment Administration Record (TAR) was updated on 3/10/15 by an R.N. to include monitoring of the rate and route of oxygen administration per physician order.<br><br>Step 2<br>A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/11/15 through 3/12/15. This review compared Physician or Nurse Practitioner orders to the Treatment Administration Record to ensure both matched; corrective action completed as indicated. On these same dates, an R.N. then validated that the oxygen treatment was implemented per physician orders; no additional findings. | |

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| {F 490} | Continued From page 11 proper health services to residents. The Administrator administers, directs and coordinates all activities of the Center to assure that the highest degree of quality of care is consistently provided to residents.<br><br>Review of the facility's Plan of Correction for the 12/19/14 survey revealed staff was educated on the facility's policy for following each resident's plan of care and the Center Administrator was responsible for the implementation of and adherence to facility policy and procedures.<br><br>Review of facility policy titled, "Care Plans", last revised 01/02/14, revealed the comprehensive, individualized care plan should be developed by the interdisciplinary team for each resident. The care plan should include measurable objectives to meet resident needs and goals as identified by the assessment process. The purpose was to provide necessary care and services to attain or maintain the patient's highest practicable physical, mental and psychosocial well being.<br><br>Review of a facility policy, titled Oxygen and dated last revised 12/08/14, revealed "Set liter flow per order".<br><br>Record review revealed Resident #13 was readmitted to the facility 02/04/15 with a Physician's order for oxygen at 2.5 L. Observation on 03/11/15 at 3:55 PM, revealed Resident #13 was in bed with oxygen being administered via nasal cannula and the oxygen concentrator was set at 5/L. Interviews on 03/11/15 with Licensed Practical Nurse (LPN) #4 at 3:56 PM, LPN #5 at 4:45 PM, RN #1 at 5.00 PM and the DON at 4:30 PM revealed the order for the oxygen did not print out on the resident's | {F 490} | A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/12/15 through 3/14/15 to ensure the resident care plan includes information regarding oxygen use; corrective action completed as indicated.<br><br>Step 3<br><br>On 3/23/2015 the Regional Vice President of Operations and the Regional Manager of Clinical Operations provided in-person re-education to the Director of Nursing and Administrator. This re-education included Administrator Responsibilities, Director of Nursing Responsibilities, Performance Improvement, and the following Policies/Procedures:<br>• Physician/N.P. order verification prior to initiating oxygen<br>• Facility policies/procedures for oxygen concentrator use<br>• Facility policies/procedures for high pressure cylinder use<br>• Facility policies/procedures for physician order transcription<br>• Provide care in accordance to each resident's plan of care<br>• Review of Administrator and Director of Nursing responsibilities which also included clinical stand up meeting and process.<br>• Quality Assurance / Performance Improvement | |

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| {F 490} | Continued From page 12 Treatment Administration Record (TAR) when the nurse typed the information in the computer so the oxygen was not on the TAR to remind nurses to check the oxygen administration amount every shift which resulted in the resident's oxygen amount not being assessed by the nurses.<br><br>Post survey interview with the Administrator, on 03/16/15 at 1:00 PM, revealed he was responsible for the day to day operations of the facility, to ensure policy and procedures were implemented and to ensure the implementation of the facility's Plan of Correction to achieve substantial compliance. He revealed a daily check during the morning meeting was done of all new admissions and orders. The Administrator stated he felt the failure was the computer had put the oxygen order in the ancillary order section and did not generate the order on the resident's TAR; and this had not been identified during the morning meeting check but should have.<br><br>Further interview (post survey) with the Administrator on 03/25/15 at 8:45 AM, revealed staff had been educated on following the care plan and validation of learning audits were conducted by interviewing staff and having them tell how they ensure care planned followed. No issues had been identified. | {F 490} | A post-test was completed to measure learning on the above re-education; this testing was provided and graded by the Regional Vice President of Operations. On 3/23/2015 the Regional Vice President of Operations and the Regional Manager of Clinical Operations attended the QAPI meeting to provide support and oversight of the meeting.<br><br>On 3/23/2015 the process for conducting month end changeover was revised through the Performance Improvement Committee. Two dedicated licensed nurses are assigned to complete changeover. Changeover responsibilities was reviewed with those two staff members by the Director of Nursing on 3/23/2015.<br><br>Step 4<br>A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is noted on the Treatment Administration Record and provided at the prescribed liters per minute. A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is included on the resident's care plan and implemented in accordance with the residents plan of care. These audits will be conducted five times a week for 14 days, | |
| {F 520}<br>SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the | {F 520} | | |

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| {F 520} | Continued From page 13 facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility's Quality Assurance (QA) Policy and the facility's Plan of Correction for the 12/19/14 survey it was determined the Quality Assessment and Assurance Committee failed to have an effective system to ensure appropriate action plans for quality deficiencies were developed and implemented to prevent reoccurrence of deficient practice. Resident #13 was observed on 03/11/15 with oxygen being administered at five (5) Liters (L) instead of the prescribed 2.5/L. Interview and record review revealed the facility's process for validating the resident's physician orders and plan of care failed to identify this discrepancy. This failure resulted in continued non-compliance at 42 CFR 483.20 Resident | {F 520} | then three times per week for four weeks and then at least once weekly for an additional four weeks.<br><br>Audit results will be reviewed by the Performance Improvement Committee monthly for the next three months. The Performance Improvement consists of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, and Nutrition Services Director. Further audits will be determined by the Performance Improvement Committee based on audit results.<br><br>The clinical meeting will be validated through a daily chart audit form that will be reviewed by the Performance Improvement Committee monthly April, May, and June.<br><br>Oxygen audits will be completed the first day of the month April, May, and June to ensure all oxygen orders were carried over during changeover and compared to physician orders.<br><br>Beginning 3/23/2015 all QAPI meetings will be reviewed by the Regional Vice President of Operations or Regional Manager of Clinical Operations for the next three months.<br><br>Completion Date: | 3/25/2015 |

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| {F 520} | Continued From page 14<br>Assessment F281 and F282.<br><br>The findings include:<br><br>Review of the facility's policy titles, "Center Quality Improvement Process", last revised 04/01/03, revealed the Quality processes were to provide a framework for structuring and implementing data-driven quality improvement and to establish and maintain a quality improvement process that would satisfy internal standards of excellence and regulatory requirements".<br><br>Review of the facility's Plan of Correction for the 12/19/14 survey revealed the Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, Clinical Reimbursement Coordinator and the Unit Manager would conduct walking rounds to observe residents' care and to ensure care plans were implemented.<br><br>Observation, interview and record review revealed Resident #13 was readmitted to the facility on 02/04/15 with Physician's Orders for oxygen to be administered at 2.5/L; however, observation revealed Resident #13 was receiving oxygen at 5L. Licensed Staff revealed residents on oxygen administration rates were checked every shift according to the TAR; however, since the order did not print out on Resident #13's TAR his/her oxygen was not checked.<br><br>Post survey interview on 03/16/15 at 1:00 PM with the Clinical Case Coordinator, revealed "Ambassador" rounds were completed weekly by assigned staff to check care plans and Physician's Orders to make sure nothing was missed. Per interview she had completed the | {F 520} | F 520<br><br>Step 1<br>A Registered Nurse assessed resident #13 on 3/10/2015 and the Nurse Practitioner re-assessed resident #13 on 3/11/15. Resident was found to have no change of condition associated with increased oxygen use. Re-education was provided to Resident #13 and spouse on the importance of not adjusting oxygen flow rate on 3/11/15 by an R.N. The Nurse Practitioner provided a clarification order for oxygen use for Resident #13 on 3/12/15. A Registered Nurse updated Resident #13's care plan on 3/10/15 to include specific oxygen orders. Resident #13's Treatment Administration Record (TAR) was updated on 3/10/15 by an R.N. to include monitoring of the rate and route of oxygen administration per physician order.<br><br>Step 2<br>A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/11/15 through 3/12/15. This review compared Physician or Nurse Practitioner orders to the Treatment Administration Record to ensure both matched; corrective action completed as indicated. On these same dates, an R.N. then validated that the oxygen treatment was implemented per physician orders; corrective action completed as indicated. | |

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| (F 520) | Continued From page 15 "Ambassador" rounds for Resident #13 and she had not identified any issues with the resident's oxygen.<br><br>Interview with the Director of Nursing (DON), on 03/11/15 at 4:30 PM, revealed licensed staff verified the rate of oxygen administration for each resident receiving oxygen therapy and documented the verification on the resident's TAR; however, Resident #13's rate of administration of oxygen was not on the resident's TAR. She stated the oxygen orders should have printed on the TAR from the orders when the resident was admitted. The DON revealed the computer prints the TARs from the orders that are typed in. The DON stated someone should have noticed it did not print to the TAR and hand printed it on the TAR. The DON revealed all admissions orders and new orders were reviewed in the morning meeting to verify the orders to the TARs and MARs; however, they had missed Resident #13's TAR did not have his/her oxygen order on it. Additionally, she revealed the first of the month order to MAR/TAR checks should have identified the oxygen administration rate was not on Resident #13's TAR.<br><br>Further interview (post survey) with the DON, on 03/25/15 at 8:35 AM, revealed she oversees the morning meetings and nurses who conduct the monthly checks and felt Resident #13's order not being on the TAR had just been overlooked. She stated she conducted spot checks to ensure the monthly MARs and TARs were checked by the nurses, however, she had not identified an issue with Resident #13's TAR. Per interview, the "Ambassador" rounds would not include oxygen checks because they were not necessarily | (F 520) | A Registered Nurse (R.N.) reviewed residents receiving oxygen therapy on 3/12/15 through 3/14/15 to ensure the resident care plan includes information regarding oxygen use; corrective action completed as indicated.<br><br>Step 3<br><br>On 3/23/2015 the Regional Vice President of Operations and the Regional Manager of Clinical Operations provided in-person re-education to the Director of Nursing and Administrator. This re-education included Administrator Responsibilities, Director of Nursing Responsibilities, Performance Improvement, and the following Policies/Procedures:<br>• Physician/N.P. order verification prior to initiating oxygen<br>• Facility policies/procedures for oxygen concentrator use<br>• Facility policies/procedures for high pressure cylinder use<br>• Facility policies/procedures for physician order transcription<br>• Provide care in accordance to each resident's plan of care<br>• Review of Administrator and Director of Nursing responsibilities which also included clinical stand up meeting and process. | |

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| {F 520} | Continued From page 16 completed by a clinical person and the walking rounds were conducted to ensure Certified Nurse Aides were following the care plan.<br><br>Post survey interview with the Administrator, on 03/16/15 at 1:00 PM, revealed QA had focused on scope of practice on the previous deficiency and the failure to implement care plans based on a change of condition. The Administrator stated oxygen orders, documentation and administration by the licensed staff had not been identified or addressed in the QA process. He stated there was a process for all admission orders and new orders to be checked with the MAR and TAR during the morning meeting; however, staff failed to identify the order was not on the TAR at that time and should have. | {F 520} | • Quality Assurance / Performance Improvement<br>A post-test was completed to measure learning on the above re-education; this testing was provided and graded by the Regional Vice President of Operations. On 3/23/2015 the Regional Vice President of Operations and the Regional Manager of Clinical Operations attended the QAPI meeting to provide support and oversight of the meeting.<br><br>On 3/23/2015 the process for conducting month end changeover was revised through the Performance Improvement Committee. Two dedicated licensed nurses are assigned to complete changeover. Changeover responsibilities was reviewed with those two staff members by the Director of Nursing on 3/23/2015.<br><br>Step 4<br>A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is noted on the Treatment Administration Record and provided at the prescribed liters per minute. A Registered Nurse or Licensed Practical Nurse will conduct audits to validate oxygen therapy is included on the resident's care plan and implemented in accordance with the residents plan of care. These audits will be | |

conducted five times a week for 14 days, then three times per week for four weeks and then at least once weekly for an additional four weeks.

Audit results will be reviewed by the Performance Improvement Committee monthly for the next three months. The Performance Improvement consists of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, and Nutrition Services Director. Further audits will be determined by the Performance Improvement Committee based on audit results.

The clinical meeting will be validated through a daily chart audit form that will be reviewed by the Performance Improvement Committee monthly April, May, and June.

Oxygen audits will be completed the first day of the month April, May, and June to ensure all oxygen orders were carried over during changeover and compared to physician orders.

Beginning 3/23/2015 all QAPI meetings will be reviewed by the Regional Vice President of Operations or Regional Manager of Clinical Operations for the next three months.

Completion Date: 3/25/2015