

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

Acceptance
12/18/12

PRINTED: 11/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER ST CLARE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
(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)

F 000 INITIAL COMMENTS

A Standard Recertification Survey was conducted 11/12/12 through 11/13/12. Deficient practice was identified and a deficiency was cited at a Scope/Severity of a "D".

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

SS=D

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, record review it was determined the facility failed to ensure services provided met professional standards of quality for two (2) of four (4) sampled residents (Residents #1 and #4). Resident #1's oxygen was ordered to be administered at three (3) liters per minute (LPM), observation revealed the oxygen to be set at two (2) LPM. Resident #4 had an order for weights to be obtained every three (3) days; however, the facility failed to obtain the weights every three (3) days.

The findings include:
Interview, on 11/13/12 at 3:25 PM, with the Administrator revealed there was no facility policy on following Physician's Orders. She stated, following Physician's Orders was a standard of practice for nurses.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 11/08/12 with diagnoses which included Chronic

F 000 sure of Oxygen dosage:
Corrective action – Resident #1 was affected directly. The oxygen LPM was immediately adjusted to correct dose after surveyor brought it to attention of staff on 11/13/12. Dose and oxygen saturation was continually checked on each nursing shift until resident's discharge on 11/20/13. RN and RT were counseled verbally by DON immediately.

F 281
Other current residents using oxygen were identified (1) and dose was checked for accuracy – It was accurate.
DON checked all current resident oxygen orders against dosage each morning from 11/14/2012 until mandatory unit meeting on 11/28/12.

A mandatory unit meeting was completed on 11/28/12 regarding Nursing law and regulations on following of physician orders, and regarding checking oxygen dosage during head to toe assessment per shift. Any nursing staff not in attendance were required to read and sign a written summary of this by 12/7/12. The DON ensured this was done.
Any staff not complying will not be allowed to work until this has been completed.

RT Director remediated the RT involved. Their policy states that the RT check Oxygen dosage at each visit to make sure it follows physician order OR the Respiratory Department's titration policy if orders are written to titrate.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE NHA Administrator	(X8) DATE 12/7/12
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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
Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF).

Review of the Admission Assessment, dated 11/08/12, revealed the resident was assessed as being alert and oriented to person and place. Review of the admission Physician's Orders revealed an order for the resident to receive oxygen at three (3) liters per minute (LPM) per nasal cannula.

Observation, on 11/13/12 at 8:10 AM and 9:10 AM revealed the resident's oxygen flowmeter was set on two (2) liters per minute.

Interview, on 11/13/12 at 9:10 AM, with the Nurse Manager revealed the resident's oxygen was set on two (2) liters per minute; however, should have been set on three (3) liters per minute as ordered.

Interview, on 11/13/12 at 9:17 AM, with the Respiratory Therapist (RT) revealed Resident #1's oxygen was on two (2) liters as that was what he/she had been on at home. After reviewing the resident's medical record the RT stated Resident #1's oxygen should have been set on three (3) LPM as ordered by the Physician.

Interview, on 11/13/12 at 3:25 PM, with the Administrator revealed Resident #1's oxygen should have been set on three (3) LPM as ordered by the Physician.

2. Review of Resident #4's medical record revealed the facility admitted the resident on 10/31/12 with diagnoses which included Diabetes Mellitus and Multiple Sclerosis.

The DON will spot check oxygen dosage versus ordered dosage during DON morning rounds as a third check and remediate staff immediately as needed.

Findings will be reported to the TCU QA committee that meets Quarterly. The QA committee consists of the Administrator, DON, Medical Director, RN, Activity Therapist, PT, Dietician, Social Worker, MDS Coordinator, Risk and Compliance Manager, pharmacist and Admissions Coordinator. All audit results are documented, analyzed and trended by the TCU QA Committee to identify opportunities for improvement and take appropriate and immediate action. The TCU QA Committee will develop and implement appropriate plans of action to correct identified quality deficiencies.

Issue of ordered weights being missed:

Corrective action – Resident #4 was affected directly. The resident was weighed immediately after surveyor brought the error to the attention of DON on 11/13/12. Weights were checked every third day by DON until resident's discharge on 11/19/12.

The other current residents' (3) weight orders were checked for accuracy immediately. DON checked all current resident weights daily against orders each morning from 11/14/2012 until mandatory unit meeting on 11/28/12.

A mandatory unit meeting was completed on 11/28/12 regarding Nursing law and regulations on following of physician orders, and regarding weighing of resident per physician orders. A whiteboard was set up in the nurses station with reminders for each resident's weigh date. Charge nurse is to check that it has been completed each shift.

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F 281

Continued From page 2

Review of the Admission Assessment, dated 10/31/12, revealed the resident was assessed as being alert and oriented to person and place. Review of the admission Physician's Orders, dated 10/31/12, revealed an order for the resident to be weighed every three (3) days. Further record review revealed the facility obtained Resident #4's weight on 11/02/12 and did not obtain the next weight until 11/11/12, nine (9) days later. Further review revealed no documented evidence Resident #4's weight was obtained on 11/05/12 or 11/08/12, which would be every three (3) days as per the Physician's Order.

Interview, on 11/13/12 at 4:15 PM, with the Nurse Manager revealed the resident's weights should have been obtained every three (3) days as ordered.

Interview, on 11/13/12 at 3:25 PM, with the Administrator revealed there was no facility policy on following Physician's Orders. She stated that was a standard of care. An additional interview, on 11/13/12 at 4:36 PM, with the Administrator revealed Resident #4's weights should have been obtained every three (3) days as ordered. According to the Administrator, this was unacceptable.

The Director of Informatics (RN) completed training for the staff on entry of weights into the EMR system as there was some question as to whether it was being saved in the EMR correctly by the user. These trainings were completed on 11/13/12, 11/14/12, 11/15/12, 11/19/12 and 11/20/12. The training was also repeated at the unit meeting on 11/28/12. The Director of Informatics will be available as needed ongoing.

The DON will continue to check weights compared to order during DON morning rounds and remediate staff immediately as needed.

The weights have also been added to the chart audits that are completed weekly by the admin assistant. Actual weights taken will be checked against physician orders.

All Findings will be reported to the TCU QA committee that meets quarterly. The QA committee consists of the Administrator, DON, Medical Director, RN, Activity Therapist, PT, Dietician, Social Worker, MDS Coordinator, Risk and Compliance Manager, pharmacist and Admissions Coordinator. All audit results are documented, analyzed and trended by the TCU QA Committee to identify opportunities for improvement and take appropriate and immediate action. The TCU QA Committee will develop and implement appropriate plans of action to correct identified quality deficiencies.

12/8/12

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan approval date: 1976</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF</p> <p>Type of structure: Seven story Type I (332)</p> <p>Smoke Compartment: Two</p> <p>Fire Alarm: Complete fire alarm</p> <p>Sprinkler System: Complete sprinkler system</p> <p>A standard Life Safety Code survey was conducted on 11/13/12. Saint Claire Medical Center was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was five (5). The facility is licensed for ten (10) beds.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: NHA (X6) DATE: 12/10/12

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