

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

RECEIVED
OCT 05 2011

PRINTED: 09/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES C 09/12/2011
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NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303
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F 000	INITIAL COMMENTS	F 000		
F 309 SS=E	<p>An abbreviated survey was initiated and concluded on 09/12/11 for complaints KY16541 and KY16507. The Division of Health Care Services found KY16541 unsubstantiated with no regulatory violations. KY16507 was found unsubstantiated; however, unrelated regulatory violations were identified with deficiencies cited.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Procedure and the Amendment to the Respiratory Therapy Services Agreement, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for three (3) of (4) sampled residents, Residents #2, #3 and #4. Each resident had a Physician's order for oxygen. Resident #2 had an order for continuous oxygen and was observed without his/her oxygen. Resident #3 had an order for continuous oxygen and was found with an empty tank of oxygen attached to the nasal cannula he/she was wearing. Resident #4 had no oxygen attached to his/her nasal cannula and tubing while worn in place to the nose.</p>	F 309	<p>Resident #2 was discharged from the facility on 9/16/2011.</p> <p>Resident #3 chart review and assessment was completed on 9/26/2011. Orders were received in regard to oxygen. Orders are for Licensed Nurse to check oxygen every 2 hours for placement and function. Orders were placed on residents treatment administration record. SRNA's assignment sheets were reviewed and updated accordingly. Residents care plan was reviewed and updated accordingly.</p> <p>Resident #4 chart review and assessment was completed on 9/22/2011. Orders were received in regard to oxygen. Orders are for Licensed Nurse to check oxygen every 2 hours for placement and function. Orders were placed on residents treatment administration record. SRNA's assignment sheets were reviewed and updated accordingly. Residents care plan was reviewed and updated accordingly.</p>	10/12/11

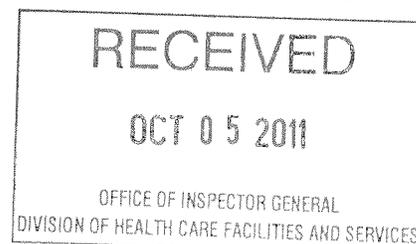
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **NED** X 10/5/11

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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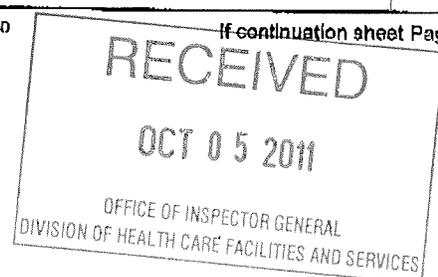
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F 309	Continued From page 2 Record review for Resident #2 revealed the facility admitted the resident on 09/02/11 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and had a physician's order for continuous oxygen. The Care Plan for Resident #2 included oxygen use as ordered. Observation, on 09/12/11 at 10:45 AM, revealed Resident #2 sitting in a wheel chair with no oxygen in use. The oxygen tubing and nasal cannula were observed on the bedside table. The oxygen concentrator was running; however, no oxygen tubing was in place to the resident's nose. Interview, on 09/12/11 at 10:45 AM, with Resident #2 revealed he/she was not given portable oxygen when he/she was out of the room. The resident stated "it won't go nowhere" referring to his/her oxygen tank. A portable tank was not observed in the resident's room. The resident voiced he/she had just returned from being out of the room. Record review for Resident #3 revealed the facility admitted the resident on 12/14/10 with diagnoses of Hypertension, Diabetes and Pneumonia. The care plan noted Resident #3 had a physician's order for continuous oxygen related to the past Pneumonia. Interview, on 09/12/11 at 11:10 AM, with Resident #3 revealed the portable oxygen tank on the back of the wheelchair was empty. The resident placed his/her fingers over the prongs of the nasal cannula and could not feel any oxygen flowing. The tank registered empty.	F 309	DNS/ADNS/Unit Managers will conduct random audits 3 days every week of residents with oxygen orders to ensure compliance. Results of audits will be presented to the Performance Improvement Committee monthly x 3 months with appropriate action as indicated.	10/12/11



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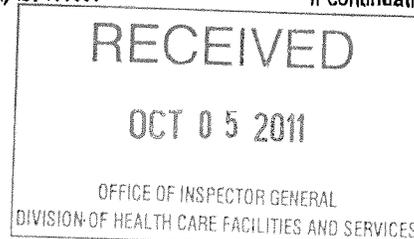
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F 309	Continued From page 3 Interview and observation, on 09/12/11 at 2:00 PM, with Resident #2 revealed the resident in his/her room in bed and stated "I am just going to lay down." No oxygen was observed on the resident and no staff was present in the room. Observation, on 09/12/11 at 2:10 PM, revealed Resident #4 sitting in a wheelchair in a common area with oxygen tubing and the prongs of the nasal cannula in his/her nose without the portable oxygen tank on the back of the chair connected to the tubing. Continued interview, on 09/12/11 at 2:10 PM, with the Activities Director revealed the oxygen tank of Resident #4 was empty. She was bringing a full oxygen tank to Resident #4 in the common area. Nursing staff often fail to fill the oxygen tank for Resident #4 and it was not uncommon for her to have to fill the tank. Continued interview, on 09/12/11 at 2:12 PM, with the MDS coordinator revealed by evidence of the empty oxygen cylinder, it was not being checked by the nurses when the resident was leaving their room in a wheelchair. Continued interview, on 09/12/11 at 2:20 PM, with Registered Nurse (RN) #2 revealed prior to a resident leaving the building "we would make sure it was full". A drop in blood oxygen saturation would be a consequence should the nurse fail to ensure a full tank. Continued interview, on 09/12/11 at 2:25 PM, with RN #3 revealed any member of the staff that happens to be caring for the resident was to	F 309			



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F 309	<p>Continued From page 4</p> <p>ensure the tank was full. When a resident leaves the building, the nurse signing out the resident was responsible to ensure a full tank of oxygen. The gauges on the portable oxygen tanks do not work. She stated "I don't know a resident that has a gauge that works" properly. To know the oxygen tank is full "we have to adjust it and jiggle it". The Amendment Respiratory Therapy Services was not performing preventative maintenance as evidenced by oxygen tanks that do not have working gauges.</p> <p>Interview, on 09/12/11 at 2:35 PM, with Certified Nursing Assistant (CNA) #1 revealed both the nurses and the CNAs are to make sure the portable oxygen tanks are full. They are checked every shift. There are gauges that do not work. She stated those have been "hung up and the oxygen supplier notified".</p> <p>Interview, on 09/12/11 at 2:45 PM, with the Assistant Director of Nursing (ADON) revealed training for the staff on the portable oxygen tanks included being able to read the gauges and know the level of oxygen in the tank. The one responsible to ensure the portable oxygen tank was full when a resident leaves the building was the nurse. She stated the nurse's "usually do it".</p> <p>Interview, on 09/12/11 at 6:35 PM, with the Unit Manager for Unit Three (3) and Four (4) revealed the charge nurse on the unit was responsible to make sure oxygen was on the resident if there was an order. "They sign the treatment book" the resident had the oxygen on. The CNA was aware the resident was to have oxygen because it was noted on the CNA assignment sheet. However, a review of the CNA assignment sheet</p>	F 309		



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F 309	<p>Continued From page 5</p> <p>for Resident #2 revealed there was no oxygen listed for use by the resident, even though the physician's order stated continuous oxygen.</p> <p>Interview, on 09/12/11 at 6:40 PM, with the Unit Manager for Unit Five (5) and Six (6) revealed the charge nurse was responsible to make sure the oxygen was in use by the resident. The nurse accomplished this through monitoring the record and visualizing the oxygen on the resident. The CNA would know if a resident was to have oxygen by checking their assignment sheet. However, the assignment sheet for Resident #2 failed to list the ordered oxygen. If a resident was to go without the ordered oxygen it would be "potentially harmful". Also, the CNA or the charge nurse was responsible to ensure the portable oxygen tank was filled for resident use.</p> <p>Interview, on 09/12/11 at 7:15 PM, with the Unit Manager for Unit One (1) and Two (2) revealed the nurses and the CNAs are responsible to ensure the oxygen tanks are filled, as are the unit managers.</p> <p>Interview, on 09/12/11 at 7:45 PM, with CNA #2 revealed the CNAs are responsible to have oxygen on residents, if an order for oxygen is available, when the resident was out of their room. The CNA was responsible to make sure it (the oxygen tank) was full. The tank was checked during the shift and also checked if the resident was going out of the building. She revealed the charge nurse was to make sure the oxygen was full when a resident leaves the building.</p>	F 309			

