

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

PRINTED: 03/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2015
NAME OF PROVIDER OR SUPPLIER DANVILLE CENTRE FOR HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 841 NORTH THIRD STREET DANVILLE, KY 40422		
(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	INITIAL COMMENTS	F 000	The following constitutes Danville Centre of Health and Rehabilitation's plan of correction for the deficiency cited and will serve as the facilities credible allegation that compliance will be achieved on 4/13/2015. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with an claim or statement herein.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	It is the practice of this facility to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or 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 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).	
	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 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).		It is the practice of this facility to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or 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 condition is or clinical complications) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequence, 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).	
	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.		It is the practice of this facility to record and periodically update the address and phone number of the resident's legal representative or interested family member.	
	The facility must record and periodically update the address and phone number of the resident's			

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

TITLE

(X6) DATE

Administrator

4-8-15

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 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to immediately inform the resident's physician of a change in condition for one (1) of four (4) sampled residents (Resident #4), and failed to notify the responsible party for one (1) of four (4) sampled residents (Resident #3) when the resident experienced a change in condition. Resident #4 had edema on 03/09/15 to the lower extremities. Nursing staff was made aware but failed to immediately notify the physician. Resident #3 had a scabbed area to the left foot on 03/12/15. The facility failed to contact the resident's responsible party to inform them of the resident's change of condition.</p> <p>The findings include:</p> <p>A review of the facility's "Change in a Resident's Condition or Status" policy, with a revised date of October 2013, revealed facility staff shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).</p> <p>1. A review of the medical record for Resident #4 revealed the resident was admitted by the facility on 04/18/13 with diagnoses that included Vitamin Deficiency, Iron Deficiency, Anemia, Depressive Disorder, Hypertension, Diaphragmatic Hernia, Constipation, Lumbosacral Disc Degeneration, Generalized Pain, Edema, Failure to Thrive, and Rehabilitation.</p>	F 157	<p>1.) On 03/17/2015 Resident #3's Responsible Party was notified of the change in condition for a scabbed area on the left foot from 03/12/2015. On 03/12/15 Resident #3's MD had been notified and new orders had been received from MD to observe scab for any change. On 3/17/2015 an SBAR was completed by the Director of Nursing on scabbed area on left foot and responsible party was notified of the updated MD orders.</p> <p>On 3/10/2015 Resident #4's primary physician was notified by LPN #2 for edema in lower extremities that was brought to RN #1's attention by the resident's Responsible Party on 3/9/2015.</p> <p>On 3/10/2015 LPN #2 obtained new orders from MD for Lasix x7 days. Responsible Party was notified of updated orders on 3/10/2015.</p> <p>RN #1 is no longer employed by this facility.</p> <p>Resident #3's care plan was reviewed and updated and resident's face sheet was reviewed to ensure current and correct contact information was in-place.</p> <p>Resident #4's care plan was reviewed and updated and resident's face sheet was reviewed to ensure current and correct contact information was in-place.</p>	3/17/2015	

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F 157	<p>Continued From page 2</p> <p>An interview conducted with Resident #4's responsible party (RP) on 03/16/15 at 10:47AM, revealed when the RP was visiting Resident #4 on 03/09/15 he/she noticed swelling to the legs. The RP stated she notified Registered Nurse (RN) #1 of the change in Resident #4's condition.</p> <p>Further review of Resident #4's medical record revealed no documentation of edema to Resident #4's legs and no evidence that the resident's physician was notified on 03/09/15 of the resident's change in condition.</p> <p>An interview was conducted with RN #1 on 03/17/15 at 1:48 PM. RN #1 stated she cared for Resident #4 on 03/09/15 and the resident's RP reported to her that Resident #4 had edema in the lower extremities. RN #1 stated Resident #4 had a small amount of edema (trace to 1+). RN #1 further stated she did not document the edema due to being "busy" but did elevate the resident's legs. RN #1 further stated she did not contact the physician because it was after 7:00 PM and "the doctor doesn't like to be called at night."</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 03/17/15 at 6:08 PM revealed, "Resident #4 normally has a little of bit of swelling to (his/her) legs, but nothing alarming." LPN #2 stated on the morning of 03/10/15 the aides requested the LPN to look at Resident #4's feet. The LPN stated Resident #4 was noted to have 3+ (moderate to large amount) pitting edema. The LPN stated she asked the aides if the edema was present on the previous day and was told that the edema was not present the day before. LPN #2 stated she notified the physician and was given an order</p>	F 157	<p>2.) A 90-day chart audit will be completed by the Admin, Assistant Admin, DON, ADON and Unit Managers. The look-back window on the audit will be from 03/31/15 to 12/17/2014. This audit will review all Physician Orders and Nursing Notes to identify any resident that had a change in condition where MD and Responsible Party should have been notified and were notified. This audit will be completed on 4/8/2015.</p> <p>3.) On 4/1/2015 The Director of Nursing reviewed the policy for a resident's change in condition, and the policy was determined to be sufficient. In-service training for all appropriate staff including; LPNs, RNs, Rehab staff, and Nursing Management will be completed by the Director of Nursing, and the Assistant Director of Nursing. Educational content consisted of Federal Regulation 157, utilization of the SBAR (Situation, Background, Assessment, and Request/Plan) tool, the facility's policy and procedure for physician and family notification, and on Interact 3.0 Acute Changes in Condition in the Long-Term Care Setting.</p> <p>All responsible staff that may be responsible for MD and family notification, including; LPNs, RNs, Rehab Staff, and Nursing Management staff will be in-serviced by the Director of Nursing and the Assistant Director of Nursing on the facility's Charting and Documentation Policy.</p>	4/13/2015 4/13/2015	

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F 157	<p>Continued From page 3 for Lasix (diuretic) and notified the RP.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 03/17/15 at 2:16 PM revealed if a resident has a change in condition or a new area to the skin they are to report to the nurse immediately. Further interview with SRNA #3 revealed he gave care to Resident #4 daily and stated he first noticed Resident #4's swelling on 03/10/15 while assisting the resident with care. SRNA #3 stated this was not normal for the resident and immediately reported the change of condition to LPN #2.</p> <p>2. A review of the medical record for Resident #3 revealed the resident was admitted by the facility on 10/12/11 with diagnoses that included Chronic Kidney Disease, Hypertension, Anxiety, Hypothyroidism, Vitamin Deficiency, Generalized Pain, Allergic Rhinitis, Atrial Fibrillation, Transient Cerebral Ischemia, Urinary Tract Infection, Malnutrition of moderate degree, Hyperlipidemia, and Umbilical Hernia.</p> <p>A review of Resident #3's medical record revealed a physician's telephone order dated 03/12/15 to observe a scab to the top of the left foot for changes. A review of the nurse's notes revealed the resident had a scab to the top of the left foot and staff was to observe for changes. Further review of the medical record revealed no evidence that the resident's RP was notified on 03/12/15 of the change in the resident's condition.</p> <p>An interview was conducted with Resident #3's RP on 03/17/15 at 3:38 PM. The RP stated she was not notified of the scab on Resident #3's foot on 03/12/15. The RP stated facility staff informed her the day of the survey of the scab after the RP</p>	F 157	<p>A copy of the Interact 3.0 Acute Changes in Condition in the Long-Term Care Setting, Acute Condition Changes - Clinical Protocol, and a copy of the facility's policy on Physician and family notification has been added to each unit's nurses station as a resource for the nurses to help identify changes in condition that require physician and family notification.</p> <p>Starting on 4/13/2015, all appropriate new hires are given copies of the facility's charting and documentation policy, and the physician and family notification policy as apart of their orientation packet. Staff Development will ensure proper in-services are completed during the orientation process to ensure all new licensed nursing staff are educated on facility systems related to timely physician and family notification.</p> <p>4.) All residents placed on the 24 report will have their charts reviewed for proper documentation and charting to ensure physician and family notification was completed timely. Director of Nursing and Assistant Director of Nursing and Unit Manger will complete weekly x4 random follow-ups on all documented physician and family notifications due to a change in condition. If it is determined in the random follow-up that notification had not been then it will be done so be the Licensed Nurse.</p>	4/13/2015

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F 157	<p>Continued From page 4 saw the scab while visiting and asked about it.</p> <p>An interview conducted with RN #2 on 03/17/15 at 5:05 PM revealed on 03/12/15, Resident #3 was noted with a scab on the top of the left foot. RN #2 stated she attempted to notify the RP twice on 03/12/15, but was unable to leave a voice message and did not document the attempt to notify the RP. RN #2 stated she notified the MD, but did not complete the Situation, Background, Assessment, and Recommendation (SBAR) form.</p> <p>An interview conducted with the Director of Nursing (DON) on 03/17/15 at 6:58 PM, revealed when a resident has a change in condition, the nurse assigned to the resident should fill out an SBAR form, notify the resident's attending physician, and notify the resident's responsible party as required by the facility's policy. Further interview with the DON revealed RN #1 did not follow facility policy by not contacting Resident #4's physician during a change in condition. The DON revealed the facility did not follow their policy by not contacting the RP and failed to complete the SBAR form related to Resident #3's change in condition.</p> <p>Interview with the Administrator on 03/17/15 at 7:07 PM revealed the nursing staff should complete a SBAR form, document in nursing notes, and notify the physician and family when there is a change in a resident's condition. The facility administrative staff monitors the resident's change in condition during morning meetings where the facility staff reviews the documentation. Further interview with the Administrator revealed he was not aware that Resident's #4 family notified the nurse of the edema until Adult</p>	F 157	After the weekly x4 of random follow-ups a report will be made to the Administrator who will report to the QA committee to determine if further action is required as well as to determine if the time frame of said audits need to be revised/repeated more frequently.	

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F 157	Continued From page 5 Protective Services told the facility. Further interview with the Administrator revealed he was not aware of the scabbed area to Resident #3's foot and that the family was not notified.	F 157			