

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

PRINTED: 11/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/23/2014
NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351		
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F 000	INITIAL COMMENTS	F 000			
F 281 SS=D	<p>An Abbreviated Survey investigating #KY 22352 was conducted on 10/21/14 through 10/23/14 to determine the facility's compliance with Federal requirements. #KY 22352 was substantiated with deficiencies cited at the highest S/S of a D.</p> <p>The State Survey Agency validated the deficient practice was corrected on 10/19/14, prior to the State Survey Agency entering the facility, so it was determined to be past non-compliance.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy and procedures, and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement fourteen, (AOS #14), it was determined the facility failed to ensure services provided by the facility met professional standards for one (1) of three (3) sampled residents (Resident # 1), related to the failure to follow physician's orders. The facility failed to ensure professional standards of practice were followed related to following a physicians order to remove the remaining skin staples from Resident #1's right knee on 10/06/14.</p> <p>The findings include:</p> <p>Review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement fourteen, (AOS #14),</p>	F 281	Past noncompliance: no plan of correction required.		

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.

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F 281	<p>Continued From page 1</p> <p>last revised 10/2010, revealed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were required to administer medications and treatments prescribed by the physician, physician assistant, dentist and advanced practice registered nurse.</p> <p>Review of the facility's policy titled "NSG117 Transcription of Orders, last revised 10/01/12, revealed orders from an authorized independent practitioner should be transcribed by a licensed nurse. The policy and procedure for physician order transcription was as follows: 1. Review the orders and clarify if necessary. 2. Check for allergies and notify the physician, if indicated. 3. Write the orders; write it on a physicians's order sheet, make a nurses note and notify family, update the care plan, put the order in Point Click Care, fax to pharmacy if indicated. 4. Transcribe the new order to the MAR/TAR, update calendar and lab book as indicated. 5. Put new order on the 24 hour report, verbally communicate any new orders during shift report.</p> <p>Record review revealed Resident #1 was admitted to the facility on 01/25/14 with diagnoses which included Depressive Disorder, Diabetes with out complications, and Osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/30/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of eleven (11) indicating he/she was interviewable. The resident required extensive assistance from staff for all care,</p> <p>Record review revealed on 09/26/14 Resident #1 was re-admitted to the facility following a Right Knee Arthroplasty with a follow up appointment</p>	F 281			

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F 281	<p>Continued From page 2</p> <p>with the Orthopedic Surgeon on 09/30/14 and one half of the skin staples were removed from the resident's right knee on that visit.</p> <p>Review of a Physician's Order, dated 09/30/14, revealed to remove the remaining staples from the resident's right knee on 10/06/14.</p> <p>Review of Resident #1's October 2014 Treatment Administration Record (TAR), revealed there was no documentation of the physician's order to remove the skin staples from the residents right knee on 10/06/14</p> <p>Interview with Registered Nurse (RN) #1, on 10/21/14 at 5:00 PM, revealed she was the nurse working the day Resident #1 returned from the follow-up appointment with the orthopedic surgeon on 09/30/14. She revealed the resident's daughter came in with the new physicians orders and they were processed, she placed them on the calendar and the twenty four (24) hour shift report and updated the care plan with the new orders. She stated it was processed the same way as any written order except she could not recall if it was written on the TAR, but it was on the calendar and the 24 hour report. She stated "she does not know why it didn't get done". She revealed that every nurse was responsible to check the calendar every shift and if it wasn't marked off then they would know it still needed to be done.</p> <p>Interview with RN #3, on 10/22/14 at 3:00 PM, revealed she was working on 10/12/14 and was assigned as Resident #1's nurse. She stated the resident's daughter called her on the phone and asked if the skin staples were still in place in the resident's right knee. She revealed that she</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>checked the orders and saw they were ordered to be removed on 10/06/14. Further interview revealed she removed twenty-five (25) skin staples from Resident #1's right knee without difficulty on 10/12/14. She stated the resident did not complain of pain during the procedure and there was only slight redness at the site and a small scabbed area. She stated she did not know how it got missed, every single nurse was responsible to make sure the calendar was checked.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 10/22/14 at 5:00 PM, revealed she has taken care of Resident #1 and every time she checked him/her she looked at the resident's right knee. She stated the resident had not made any complaints to her about the knee. She revealed the day the staples were removed (10/12/14) the knee looked good and the resident did not voice any complaints of increased pain or redness.</p> <p>Interview with Registered Nurse (RN) #2, on 10/22/14 at 10:00 AM, revealed she was familiar with Resident #1's care but she usually worked the desk. She stated she always checked the calendar daily and used it as a guide to get started every day. She revealed she knew the order to remove Resident #1's staples was on the calendar and was not sure how it got missed.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 10/22/14 at 10:10 AM, revealed the nurses were supposed to check the calendar every day to see what's due that day and were also supposed to check the TAR every day to see what was ordered for that day. She stated the calendar was used to put physicians orders, lab work and x-rays that were due, anything coming</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>up that needed to be done. She stated she was aware Resident #1's staples did not get removed when they were ordered, because she was working the night they were removed (10/12/14).</p> <p>Interview with the Director of Nursing (DON), on 10/22/14 at 3:00 PM, revealed the skin staples were removed on 10/12/14 . She stated the nurse transcribing the physician's order on 09/30/14 followed the process for transcribing physicians orders. She stated the order was placed on the twenty four (24) hour report and also placed on the calendar to be removed on 10/06/14 as per the process, but there was no documentation on the Treatment Administration Record (TAR) to remove the staples. She revealed the nurses were monitoring the site on the TAR each shift as well as cleaning the wound each shift and documenting on the TAR. She stated she felt like it was human error, and she expected the nurses to complete the physician's order as it was ordered by removing the staples on 10/06/14. She stated the nurses working that day were responsible to check the calendar as well as the TAR each shift.</p> <p>After Supervisory Review and added information provided by the facility it was determined past non-compliance on 10/29/14.</p> <p>The facility implemented the following actions to correct the deficient practice as of 10/19/14:</p> <p>1 Body audits were conducted on 10/16/14 for forty four (44) out of forty four (44) residents to ensure there no other wounds with signs or symptoms of infection. No concerns were identified.</p>	F 281			

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F 281	<p>Continued From page 5</p> <p>2. Forty-four (44) out of forty four resident records were audited to validate the physicians orders had been transcribed correctly from 08/21/14 (date of annual survey) to 10/17/14. Any concerns were addressed immediately.</p> <p>3. Forty-four (44) out of forty four Treatment Administration Records (TAR) were audited to validate that all treatment orders had been transcribed correctly to the TAR. No concerns were identified.</p> <p>4. Re-education with all licensed staff and certified staff was completed on 10/17/14. The education was provided by the Assistant Director of Nursing (ADON). Post tests were administered and graded by the ADON on the same day each employee completed the re-education.</p> <p>5. Daily audits to ensure orders were transcribed to MARs and TARs were began on 10/16/14.</p> <p>The State Surveying Agency validated the corrective actions taken by the facility as follows:</p> <p>1. Interview with the Administrator, on 10/29/14 at 3:30 PM, revealed body audits were completed on 10/16/14 with no other residents identified with wounds or any infection.</p> <p>2. Interview with the Administrator, on 10/29/14 at 3:30 PM, revealed resident record audits were completed to ensure physician's orders were transcribed to the MAR and TAR from 08/21/14 through 10/17/14.</p> <p>3. Interview with the Administrator, on 10/29/14</p>	F 281			

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F 281	<p>Continued From page 6</p> <p>at 3:30 PM, revealed TAR audits were completed to ensure all treatments had been transcribed to the TARs.</p> <p>4. Interview with RN# 2, on 10/22/14 at 10:10 AM, revealed we recently had an inservice on transcribing orders and documenting medication on the MAR and the TAR.</p> <p>Interview with LPN #2, on 10/22/14 at 10:10 AM, staff were inserviced on order processing and to make sure the order was placed on the TAR, Medication Administration Record (MAR) etc, to ensure staff don't miss anything like that again.</p> <p>Interview with the DON, on 10/22/14 at 9:30 AM, revealed the facility had re-educated the staff to utilize the twenty four (24) hour report instead of the calendar, and anything that happens during the shift that cannot be taken care of to write it on the 24 hour report and pass it on in shift report.</p> <p>Interview with the Administrator on 10/22/14 at 4:00 PM, revealed they have re-educated 100% of all licensed staff and certified staff related to the facility's policy and procedure for physician order transcription and completed a clinical competency evaluation for transcription of physician orders for each licensed staff. She revealed the education was completed on 10/17/14. Interview with the Administrator on 10/29/14 at 3:30 PM, revealed that all full time, part time and any PRN staffing were inserviced prior to returning to work.</p> <p>5. Interview with the Administrator on 10/22/14 at 4:00 PM, revealed she also had reviewed their process with their Medical Director and he feels it was sufficient to go forward. She stated they</p>	F 281			

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F 281	Continued From page 7 were currently doing audits daily to make certain the physician order process was followed. She revealed the daily audits would be completed daily for one (1) month, then five (5) days a week for three (3) months. In addition, she stated they plan to continue to follow up with it in performance improvement meetings monthly and to continue to review with the Medical Director.	F 281			