

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/16/2014
NAME OF PROVIDER OR SUPPLIER MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
(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 An Abbreviated Survey Investigating Complaint #KY 21661 was conducted on 05/14/14 through 05/16/14 to determine the facility's compliance with Federal requirements. #KY 21661 was substantiated with regulatory violations identified.	F 000		6/11/14
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's	F 157		
			<p>1. <u>Corrective Action for Identified Resident</u> – At the time of this review, the identified resident (Resident #1) had transferred to The ICCU section of Muhlenberg Community Hospital and after a few days returned to his home with Hospice Care.</p> <p>2. <u>Identification of Other Residents</u> - On 5/19/14, the Director of Nursing completed the following chart reviews relative to Physician Notification:</p> <ul style="list-style-type: none"> - 100% audit of all residents in the facility on 3/24/14 and 3/25/14 – no incidences found (See Attachment #1). - 100% audit of all other residents in the facility on 5/19/14 – no incidents found (See Attachment #1). 	

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

TITLE

(X6) DATE

Bucky Owens, NHA

Administrator

6/9/14

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 observation, interview, and record review, and review of the facility's policy and procedures, it was determined the facility failed to notify the physician of a significant change in a resident's condition for one (1) of three (3) sampled residents (Resident #1). Resident #1 had a change in condition related to his/her breathing on 03/24/14 at approximately 11:30 PM and the physician was not notified until approximately 7:00 AM on 03/25/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Acute Condition", dated 09/13, revealed "All abnormal findings or changes in condition will be reported to the physician in a timely manner."</p> <p>Review of the facility's policy and procedure titled, "Physician Notification", last revised 09/13, revealed "The attending physician shall be notified timely and appropriately in the event the resident's condition changes. Notification of a physician shall be done only after a thorough assessment of the resident has been completed. The notification process and resident assessment shall be documented in the medical record."</p> <p>Record review revealed the facility admitted Resident #1 on 12/20/13 with diagnoses which included Debility, Chronic Atrial Fibrillation, Benign Prostate Hypertrophy, Chronic Systolic Congestive Heart Failure, Mild Dementia, Osteo-Arthritis, Dysphagia, Hypertension, Anxiety,</p>	F 157	<p>F157 continued</p> <p>3. <u>Measures in Place to Ensure Deficient Practice will not Recur</u> – On 5/19/14, the policy "Physician Notification" was reviewed by the Administrator, DON, and Staff Development Coordinator and updates/corrections were made. (See Attachment #2, section 4.2).</p> <p>On 6/3/14, the Staff Development Coordinator prepared education for all staff to review and become more efficient in understanding the policy "Physician Notification". - Outline of education provided all staff (See Attachment #3).</p> <p>On 6/9/14, a letter was sent to all medical staff identified as admitting/attending physicians to Long Term Care. (See Attachment #4). A copy of the policy "Physician Notification" was included.</p> <p>4. <u>Monitoring of Correction Action</u> – Effective 6/9/14, the Clinical Care Coordinator or designee will begin monitoring all medical records of</p>		

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F 157	<p>Continued From page 2 Insomnia, Depression, and Hypothyroidism.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 05/16/14 at 7:50 AM, revealed she worked 7:00 AM to 3:00 PM on 03/24/14 and she thought this was the day the resident didn't feel well and did not get a bath related to this. She stated they did not perform a lot of care for the resident on 03/24/14 per the family's request.</p> <p>Interview with CNA #1, on 05/16/14 at 11:00 AM, revealed she had received report from first (1st) shift (7A-3P) on 03/24/14 at 3:00 PM and was told the resident was not feeling well. She stated LPN#1 and herself checked on the resident for turning and repositioning at least every two (2) hours and she checked on him every thirty (30) minutes. The sitter was at the bedside and was asked if she wanted the resident turned and would instruct them on when to or not to turn him/her. She stated between 6:00 AM and 7:00 AM on 03/25/14 the resident's breathing changed but throughout the night she did not notice a change in his breathing.</p> <p>Interview with Private Sitter #2 for Resident #1, on 05/16/14 at 8:35 AM, revealed she sat with the resident from 2:00 PM to 8:30 PM on 03/24/14 and she noticed a change in the resident's condition at 2:00 PM when she came on duty. She stated the resident appeared lethargic and was not able to eat supper that evening and could only tolerate small sips of water. Additionally, she stated the resident groaned with pain during any movement and nothing seemed to ease him/her. She stated Private Sitter #1 wrote in a notebook on 03/25/14 around 2:00 PM, the resident continued to be groaning and restless.</p>	F 157	<p>F157 continued</p> <p>residents identified as having a change in their condition to assure that physician notification has been appropriate and timely as outlined in the policy. (See Attachment #5). This monitoring will be reported through the performance improvement process to the Long Term Care staff each month and to the Quality Assurance Committee quarterly.</p> <p>5. <u>Date of Completion.</u> 6/11/14</p>		

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F 157	<p>Continued From page 3</p> <p>Interview with Private Sitter #1 for Resident #1, on 05/15/14 at 1:10 PM, revealed she went to the nursing station at approximately midnight on 03/24/14 and reported to LPN #1 that the resident's breathing was rattling and she requested a breathing treatment. She stated Resident #1 was not real responsive throughout the night. She revealed after the breathing treatment, the resident was still agitated and the resident's breathing was wheezing. She stated LPN #1 came in and assessed the resident's lung sounds, but never called the physician.</p> <p>Review of Nursing Notes, dated 03/25/14 at 12:20 AM, revealed the resident was fidgety and restless and pulling on the urinary catheter and intravenous (IV) tubing.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/14/14 at 2:55 PM, revealed toward the end of her shift between 6:30 AM and 7:00 AM on 03/25/14, Resident #1 began to have complications related to his/her breathing. LPN #1 stated, earlier in the night, at approximately 11:20 PM, Private Sitter #1 informed her the resident's breathing had changed and requested a breathing treatment for the resident. The LPN stated Respiratory Therapy was called and arrived on the unit at approximately 11:30 PM and a nebulizer breathing treatment was administered with documentation describing lung sounds before and after the treatment as "wet". Further interview revealed if she had noticed a change in the resident's condition during the night she would have notified the physician.</p> <p>Review of the Nurse's Note, dated 03/25/14 at 6:30 AM, revealed Resident #1's breath sounds were abnormal (diminished and wet), respiratory</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>rate was twenty (20), respiratory effort normal, oxygen saturation 94% on room air (normal range 95-100%) on room air, and nailbeds were pink. No other nursing documentation was completed related to the resident's change in condition.</p> <p>Interview with Registered Nurse (RN) #1, on 05/14/14 at 10:30 AM, revealed when she came on duty at approximately 6:45 AM on 03/25/14, the resident had declined significantly with respiratory distress noted as well as extremely low oxygen saturations. She stated she went to the nursing station to notify the physician who was already at the facility and he gave orders to send Resident #1 to the Intensive Care Unit in the hospital.</p> <p>Review of the Hospital Discharge Summary, dated 03/27/14, revealed a principal diagnoses on 03/25/14 of Respiratory Distress due to Acute Systolic Congestive Heart Failure. Vital signs upon admission to the Intensive Care Unit (ICU) were Blood pressure: 112/60, temperature: 97.2, Pulse 69 Irregular, and Respirations were 18. The resident had minimal responsiveness. A Hospice consult was received on 03/26/14 per the family's request and the resident was discharged home on 03/27/14.</p> <p>Interview with the Director of Nursing, on 05/14/14 at 2:25 PM, revealed she would have expected the physician be called if there was a change in condition of a resident. She stated it says that in the policy as well.</p> <p>Interview with the DON and Administrator, on 05/15/14 at 2:10 PM, revealed they both anticipated and expected nurses to document changes in a resident's condition. The nurses</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>chart by exception and each shift is assigned a 24 hour shift assessment to be completed; otherwise residents are charted on by exception. The DON stated she would have expected LPN #1 to have documented accordingly related to the resident's change in condition.</p> <p>Interview with Resident #1's Physician, on 05/14/14 at 2:00 PM, and on 05/15/14 at 3:10 PM, revealed he did not feel it would have made a difference in the outcome if he had been called during the night but he could have possibly made the resident more comfortable if he had been notified. He further stated he was aggravated that he was not called when the resident started to decline and he did not know the exact time he/she did actually decline. He believed the resident declined throughout the night but it could have happened within an hour or so with all of his comorbidities. He stated the resident had a bad heart and it finally gave out and nothing else could be found to be fixed and there was nothing that would have made a difference if he had been sent to ICU the night before or not, but he would expect nursing to call him with any change in condition of a resident.</p>	F 167			