

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

PRINTED: 05/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185394</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>04/26/2013</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST ELIZABETH FLORENCE SNF</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4900 HOUSTON ROAD<br/>FLORENCE, KY 41042</b> |
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| (X4) IO 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 |
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| F 000 | INITIAL COMMENTS<br><br>A Recertification/Relicensure Survey was initiated on 04/25/13 and concluded on 04/26/13. Deficient practice was identified at the highest scope and severity of a "D."<br><br>F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of facility's policy it was determined the facility failed to ensure a Comprehensive Plan of Care was developed for each resident to meet the resident's medical needs that was identified in the comprehensive assessment for one (1) of | F 000 | Please accept this Plan of Correction as the St. Elizabeth Skilled Nursing Facility Florence's credible allegation of substantial compliance effective <b>May 1, 2013</b> for the deficiencies noted from the survey completed April 26, 2013. It is our intent that we have substantially corrected our deficiencies per requirements in 42 CFR Part 483 subpart B.<br><br>F279 St. Elizabeth SNF Florence ensures that all residents receive services that are designed to assist them in attaining or maintaining the highest level of functioning. The services provided are based on a comprehensive assessment and identified needs and are contained in a written plan of care.<br><br>During the survey process the surveyor noted the plan of care in place for resident #4 to address his chronic lower extremity edema did not fully address the changes seen in the edema since admission. The resident had a long history of chronic lower extremity edema that had increased as his activity had increased since his admission to the facility. In addition, the resident was frequently non-compliant with interventions, i.e. elevating legs. | 5/1/13 |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy Bauer TITLE: Administrator (X6) DATE: 5/29/13

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 279 Continued From page 1  
eight (8) sampled residents (Resident #4). The facility failed to care plan and have interventions in place to address Resident #4's lower extremity edema which progressively worsened during their stay at the facility.

The findings include:

Interview, on 04/26/13 at 3:10 PM, with the Minimum Data Set (MDS) Coordinator revealed the purpose of a care plan was try to identify problems and put interventions in place for staff to follow and manage the problems identified.

Observation of Resident #4 on 04/25/13 at 11:25 AM, 12:45 PM and 4:30 PM revealed the resident was seated in a wheel chair with his/her legs down and observed to have bilateral lower extremity edema.

Observation of a skin assessment performed on Resident #4, on 04/26/13 at 9:20 AM, by Licensed Practical Nurse (LPN) #1 revealed the resident had bilateral lower extremity edema. LPN #1 assessed the resident's bilateral lower extremity edema as +2.

Interview, on 04/26/13 at 3:00 PM, with LPN #1 revealed Resident #4 had no care plan for their edema and should have been careplanned. There should have been interventions in place to keep his/her legs elevated.

Review of Resident#4's medical record revealed the resident was admitted by the facility on 04/02/13 with diagnoses which included Congestive Heart Failure, Coronary Artery Disease, Post Right Hip Surgery, and

F 279 A more in depth care plan was created on 4/26/13 following the exit conference with the surveyors. The new care plan included specific interventions and time frames. The interventions outlined were elevation of legs use of TED hose, monitoring of I&O, and daily weights.  
**See Attachment A – Care Plan/ Problem: Unintended Weight Gain, Edema.**

The Administrator and Assistant Nurse Manager met with the MDS Coordinator, nurses and CNAs on 4/26/13 following the exit conference to begin educating the staff on the development of this care plan, the interventions needed, implementation of the interventions and documentation implementation. **See Attachment B: Sign-In Sheet and Attachment C: Care Plans/Purpose and Procedure.** The in-services were completed on 4/29/13.

The Administrator and Assistant Nurse Manager monitored daily, through a review of the EMR, the documentation for compliance with the process identified in **Attachment C**. Samples of the monitoring are attached. **See Attachment D: Shift Summary, Attachment E: EMR Assessment, Attachment F: Weights and Attachment G: I&O.**

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F 279: Continued From page 2

Hypertension. Review of 04/15/13 admission MDS revealed the resident had moderate cognitive impairment. In addition, the resident required extensive assistance of two (2) staff with bed mobility, transfers, and to be walked in the room.

Review of Resident #4's medical record under the Peripheral Vascular Assessment revealed upon admit, 04/02/13, the resident had a trace amount of edema in the lower extremities. Continued review of the resident's Lower Extremity Peripheral Vascular Assessment revealed: from 04/03/13 thru 04/06/13 assessed as 2+ edema; 04/07/13 thru 04/10/13 assessed as 2+ pitting edema; from 04/11/13 thru 04/25/13 the resident was assessed as having 2+ or 3+ pitting edema in their lower extremities.

Review of Resident #4's Plan of Care (POC) revealed no care plan related to the assessed edema in the resident's lower extremities.

Interview, on 04/26/13 at 8:50 AM, with Certified Nursing Assistant (CNA) #1 revealed she occasionally takes care of Resident #4 and was not aware of any care plan interventions related to the edema.

Interview, on 04/26/13 at 8:40 AM and 2:15 PM, with Registered Nurse (RN) #4 revealed care plans were used to identify medical issues/problems and the purpose was to provide interventions for care of the resident's problems and monitor the outcome. She further stated the care plan was to provided standardized interventions. The RN stated the resident had edema, but there was no specific care plan in

F 279

The new process includes the use of the Roster Matrix to identify on admission the Care Plans required for the patient. See **Attachment H: Roster Matrix**. The data will be entered into the matrix on admission and updated as resident's condition changes. The matrix indicates what areas will be care planned and includes Edema [Excessive Weight Gain/Loss]. The matrix data will be used to direct the monitoring. The Administrator and ANM will continue monitoring care plans and documentation through the EMR for 2 weeks on all new admissions and condition changes. Then randomly monitor EMR for 2 weeks.

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F 279 Continued From page 3  
place with interventions to reduce the resident's edema.

F 279

Further interview, on 04/26/13 at 3:10 PM, with the MDS Coordinator revealed when Resident #4 was admitted the resident had a trace of edema to their lower extremities, but over the course of the assessment period the resident's edema was assessed as +2 and +2 pitting edema. She stated the edema should have been addressed in the resident's care plan with goals to monitor the outcome and update the care plan if needed. She further stated the care plan could have addressed the resident's refusal with interventions if non-compliance was an issue.

Interview, on 04/26/13 at 3:45 PM, with the Director of Nursing (DON) revealed Resident #4's edema should have been addressed in a care plan with appropriate interventions such as elevating legs when up in a chair. The DON stated staff was probably doing this at times, but was not an intervention to be monitored. She stated the purpose of the care plan was to identify what care was needed for the resident. She further stated the resident's edema worsened during his/her stay.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  
SS=D

F 309 F309

St. Elizabeth SNF Florence ensures that all residents receive services that are designed to assist them in attaining or maintaining the highest level of functioning. The services provided are based on a comprehensive assessment and identified needs are contained in a written plan of care and care provided is documented in the EMR.

5/1/13

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.

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| F 309   | Continued From page 4<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for one (1) of eight (8) sampled residents (Resident #4). The facility failed to ensure interventions were in place to address Resident #4's lower extremity edema which progressively worsened during their stay at the facility.<br><br>The findings include:<br><br>Review of Resident #4's medical record revealed the resident was admitted by the facility on 04/02/13 with diagnoses which included Congestive Heart Failure, Coronary Artery Disease, Post Right Hip Surgery, and Hypertension. Review of 04/15/13 admission MDS revealed the resident had moderate cognitive impairment. In addition, the resident required extensive assistance of two (2) staff with bed mobility, transfers, and to be walked in the room.<br><br>Interview, on 04/26/13 at 3:10 PM, with the Minimum Data Set (MDS) Coordinator revealed the purpose of a care plan was try to identify problems and put interventions in place to manage the problems.<br><br>Observation of Resident #4, on 04/25/13 at 11:25 AM, revealed the resident was seated in a wheel | F 309  | During the survey process the surveyor noted the plan of care in place for resident #4 to address his chronic lower extremity edema did not fully address the changes seen in the edema since admission, that the staff seemed unaware of the care plan and the documentation did not reflect care required by the resident. The resident had a long history of chronic lower extremity edema that had increased as his activity had increased since his admission to the facility. In addition, the resident was frequently non-compliant with interventions, i.e. elevating legs, when up in chair, using compression boots, etc. All of which were ordered for him. The documentation did not always reflect the resident's refusal and lack of compliance.<br><br>A more in depth care plan was created on 4/26/13 following the exit conference with the surveyors. The new care plan included specific interventions and time frames. The interventions outlined were elevation of legs, use of TED hose, monitoring of I&O, and daily weights.<br><b>See Attachment A – Care Plan/ Problem: Unintended Weight Gain, Edema.</b><br><br>The Administrator and Assistant Nurse Manager met with the MDS Coordinator, nurses and CNAs on 4/26/13 following the exit conference to begin educating the staff on the development of this care plan, the |                      |  |

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F 309 Continued From page 5

chair with his/her legs down. Observation revealed the resident to have bilateral lower extremity edema. Continued observation, on 04/25/13 at 12:45 PM and 4:30 PM and on 04/26/13 at 8:30 AM, revealed the resident was seated in his/her wheel chair with his/her legs down.

Observation of a skin assessment performed on Resident #4, on 04/26/13 at 9:20 AM, by Licensed Practical Nurse (LPN) #1 revealed the resident had bilateral lower extremity edema. LPN #1 assessed the resident's bilateral lower extremity edema as +2.

Review of Resident #4's medical record under the Peripheral Vascular Assessment revealed upon admission, 04/02/13, the resident had a trace amount of edema in the lower extremities. Continued review of the resident's Lower Extremity Peripheral Vascular Assessment revealed: from 04/03/13 through 04/06/13 assessed as 2+ edema; 04/07/13 through 04/10/13 the resident was assessed as 2+ pitting edema; from 04/11/13 through 04/25/13 the resident was assessed as having 2+ or 3+ pitting edema in his/her lower extremities.

Review of Resident #4's Plan of Care (POC) revealed no documented evidence of a care plan to the address edema in the resident's lower extremities.

Interview, on 04/26/13 at 8:50 AM, with Certified Nursing Assistant (CNA) #1 revealed she occasionally took care of Resident #4. She stated the resident's legs looked more swollen yesterday when she was helping to walk the

F 309

interventions needed, implementation of the interventions and documentation implementation, including documentation of resident's non-compliance and refusals. **See Attachment B: Sign-In Sheet and Attachment C: Care Plans/Purpose and Procedure.** The in-services were completed on 4/29/13.

Staff worked with resident to achieve compliance with interventions, particularly elevation of legs, use of TED hose/compression boots. Daily weights and monitoring of I&O were re-enforced. **See Attachment D: Shift Summary, Attachment E: EMR Assessment, Attachment F: Weights and Attachment G: I&O.**

The Administrator and Assistant Nurse Manager monitored daily, through a review of the EMR, the documentation for compliance with the process identified in **Attachment C**. Samples of the monitoring are attached. **See Attachment D: Shift Summary, Attachment E: EMR Assessment, Attachment F: Weights and Attachment G: I&O.**

The new process includes the use of the Roster Matrix to identify on admission the Care Plans required for the patient. **See Attachment H: Roster Matrix.** The data will be entered into the matrix on

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| F 309  | <p>Continued From page 6</p> <p>resident and looked a lot worse then she had seen before. She further stated she was not aware of any care plan interventions related to the edema.</p> <p>Interview, on 04/26/13 at 8:40 AM and 2:15 PM, with Registered Nurse (RN) #4 revealed the resident had edema which they assessed daily, but there was no specific care plan in place with interventions to reduce the resident's edema.</p> <p>Further interview, on 04/26/13 at 3:10 PM, with the MDS Coordinator revealed when Resident #4 was admitted the resident had a trace of edema to their lower extremities, but over the course of the assessment period the resident's edema was assessed as +2 and +2 pitting edema. She stated the edema should have been addressed and careplanned with interventions to try and manage the problem. She further stated the resident's edema had increased to +2 and +3 pitting edema during his/her care at the facility.</p> <p>Interview, on 04/26/13 at 3:45 PM, with the Director of Nursing (DON) revealed Resident #4's edema progressively worsened during his/her stay and should have been addressed in a care plan. She stated the resident currently had +3 edema in their lower extremities, but had not signs of Congestive Heart Failure and the Physician noted the edema was a chronic condition.</p> | F 309  | <p>admission and updated as resident's condition changes. The matrix indicates what areas will be care planned and includes Edema [Excessive Weight Gain/Loss]. The matrix data will be used to direct the monitoring.</p> <p>The Administrator and ANM will continue monitoring care plans, care provided and documentation through the EMR for 2 weeks on all new admissions and condition changes. Then randomly monitor EMR for 2 weeks to ensure continued compliance.</p> |   |

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| K 000  | INITIAL COMMENTS<br><br>CFR: 42 CFR 483.70 (a)<br><br>Building: 01<br><br>Plan Approval: 1977<br><br>Survey Under: 2000 Existing<br><br>Facility Type: Skilled Nursing Facility (SNF)<br><br>Type of Structure: Type II (222) Protected<br><br>Smoke Compartments: 2<br><br>Fire Alarm: Complete fire alarm. Updates to the system in 2006 and 2008<br><br>Sprinkler System: Complete system. Installed 1977<br><br>Generator: Three (3) Type I Caterpillar Diesel (Two (2) upgraded in 12/2012.<br><br>A life safety code survey was initiated and concluded on 04/25/13. The findings revealed St. Elizabeth Florence SNF meets the requirements for compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). No deficiencies cited. | K 000   |   |                      |   |

RECEIVED  
JUN - 3 2013  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Wendy Bauer* TITLE *Administrator* (X6) DATE *5/29/13*

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