

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

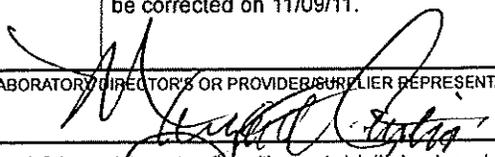
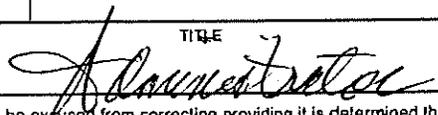
PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2011
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NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated/partial extended survey (KY #17376, KY #17022, KY #17019 and KY #17389) was conducted 11/14/11 through 11/18/11. KY #17376 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 11/18/11 at 483.13 Resident Behavior and Facility Practices, F224; and 483.20 Resident Assessment, F281 at a scope and severity of a "J". Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices.</p> <p>On 11/07/11 at 5:35 PM, Resident #1 was readmitted to the facility with a diagnosis of Pneumonia. Facility staff neglected to provide treatment to the resident, per the physician's orders. An order for oxygen at two liters via nasal cannula to maintain an oxygen saturation of equal to or greater than 92% was not administered. Additionally, the resident did not receive two scheduled nebulizer treatments, per the physician's order. Resident #1 was found at 6:30 AM on 11/08/11, unresponsive and cyanotic with an Oxygen saturation of 53 percent on room air. Resident #1 expired at the facility, on 11/08/11 at 6:44 AM. After becoming aware of the incident the facility initiated an investigation and developed a timeline of events on 11/08/11. The facility developed and implemented interventions to correct the deficiencies. Immediate Jeopardy was determined to exist on 11/07/11 through 11/08/11. It was determined the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 11/14/11, thus resulting in the determination of Past Jeopardy. The Jeopardy was determined to be corrected on 11/09/11.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 12-10-11
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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 000	Continued From page 1	F 000	F157	
F 157 SS=D	<p>KY #17022 and KY #17019 was unsubstantiated with no deficiencies. KY #17389 was substantiated with deficiencies cited.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>1. Corrective action:</p> <p>Res # 10 Inservice held for all licensed staff on 11-8-11 and given by the Corporate Nurse Trainer re-educating them on the facility policy, "Change in Resident Condition or Status" which addresses the notification of physician and family notification, specifically emphasizing the timely physician notification in the event of a significant change or incident.</p> <p>2. ID of others at risk:</p> <p>All resident medical records reviewed for notification omissions September 1, 2011 thru December 7, 2011 by the DON, ADON and Compliance Nurse on 12-8-11 and 12-9-11. No instances of omitted notifications were identified.</p> <p>3. Prevention measures:</p> <p>Corporate Nurse Trainer re-inserviced licensed staff on 11-08-11 regarding the facility policy and procedure for physician notification of any change in condition or status.</p>	

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F 157	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the physician was notified timely when there was a change in condition that had the potential for requiring physician intervention for one of three sampled residents (Resident #10). Two Licensed Practical Nurses (LPN #4 and LPN #6) observed black spots in Resident #10's percutaneous endoscopic tube (PEG Tube) (a tube for administering liquid feeding directly into the stomach). LPN #4 revealed the black spots were observed a couple of days prior to 11/01/11. LPN #6 revealed there were black spots prior to 11/01/11; however, the resident's physician was not notified until 11/01/11.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure "Change in Resident Condition or Status (N-45)" revealed the facility should timely notify the resident's attending physician of changes in the resident's medical condition. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. Notification will be made between the hours of 7:00 AM and 10:00 PM, unless it is an emergency situation or if the resident is transferred to the hospital, then notification will be made at that time.</p> <p>A record review revealed Resident #10 was admitted to the facility on 03/16/09 with diagnoses to include Aspiration Pneumonia, Multiple</p>	F 157	<p>4. Monitor:</p> <p>"Reporting Resident Incidents", CQI tool that includes the monitor of the physician notification will be initialized weekly for review for one month , then quarterly x 12 months by the DON/ADON or Compliance Nurse. Any adverse findings to be reported through the facility monthly CQI x 12 months.</p> <p>5. Date Corrected: 12-10-11</p>		

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F 157	<p>Continued From page 3</p> <p>Sclerosis and Muscle Weakness. He/she was alert/oriented and able to make his/her needs known. Further review of the record revealed the resident required nourishment via a PEG Tube when he/she was unable to take food or fluids by mouth, during an exacerbation of Multiple Sclerosis in May 2011. The resident improved and took medications and all meals by mouth in the dining room with the staff's assistance and was care planned for bolus tube feeding only if consumption was less than 50%. A review of the physician's order, dated 10/28/11, revealed "clean PEG with soap and water, pat dry every shift, everyday and every night. Flush PEG with 300 ml sterile water three times daily (TID) everyday."</p> <p>An interview with LPN #4, on 11/17/11 at 12:00 PM, revealed Resident #10 had black spots in the resident's PEG Tube. LPN #4 revealed she noticed the black spots which "looked like mold" a couple of days prior to 11/01/11 and there was an odor to the PEG Tube. She stated "I chose to monitor it" and said she "worked it out" of the PEG Tube. The physician was not notified until 11/01/11 and a referral to endoscopy was made for changing the PEG Tube.</p> <p>An interview with LPN #6, on 11/18/11 at 2:00 PM, revealed, prior to 11/01/11, she had noticed black spots inside the PEG Tube and thought it was medication residue (the resident took medications by mouth). She stated she had moved the PEG Tube around by hand and "there were more spots by the end of the week."</p> <p>Further interview with LPN #6 revealed she could not remember exactly, but there "was a time frame" when the black spots were first noticed</p>	F 157			

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F 157	Continued From page 4 and when the physician was notified on 11/01/11. Additionally, the LPN stated the physician should have been called when the black spots were first observed. A review of Resident #10's nursing notes dated and timed, 11/01/11 at 8:00 AM, revealed "MD here for lab review and complaint of black spots in PEG Tube." An interview with Resident #10's physician, on 11/18/11 at 10:35 AM, revealed he expected to be notified when there was a change in a resident's status. The physician stated that staff did notify him of the condition of the PEG Tube on 11/01/11, but he was unaware the condition was there prior to that date. An interview with the Director of Nursing (DON), on 11/18/11 at 9:55 AM, revealed the physician should have been notified of the change in Resident #10's condition when it was identified.	F 157			
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Pharmacy Delivery Sheet, the Kentucky Certificate of Death, and facility policy/procedure, it was determined the facility failed to implement written policies and	F 224	Past noncompliance: no plan of correction required.		

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F 224	<p>Continued From page 5</p> <p>procedures that prohibit neglect of residents for one of four residents (Resident #1). The facility failed to ensure staff followed the "Abuse, Neglect, or Exploitation" policy/procedure to ensure residents received the necessary services to avoid physical harm. On 11/07/11 at 5:35 PM, Resident #1 was readmitted to the facility with a diagnosis of Pneumonia. Facility staff neglected to provide oxygen and two scheduled nebulizer treatments, per the physician's orders. Resident #1 was found at 6:30 AM on 11/08/11, unresponsive and cyanotic with an Oxygen saturation of 53 percent on room air. Resident #1 expired at the facility, on 11/08/11 at 6:44 AM, related to Respiratory Failure due to Pneumonia.</p> <p>The failure to provide treatment for a resident has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. The Immediate Jeopardy with substandard quality of care was determined to exist on 11/07/11 through 11/08/11. The facility implemented corrective actions which were completed prior to the State Agency's investigation on 11/18/11, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be corrected on 11/09/11.</p> <p>Findings include:</p> <p>A review of the "Abuse, Neglect, or Exploitation" policy/procedure, revised 04/12/10, revealed it was essential for all staff, volunteers, and visitors to be responsible for the health, safety, and welfare of all individuals receiving support. Employees were prohibited to exploit, neglect, or abuse residents served. "Neglect" was defined in the policy as the failure to provide goods and</p>	F 224			

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F 224	<p>Continued From page 6</p> <p>services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>A record review revealed Resident #1 was readmitted to the facility on 11/07/11 at 5:35 PM, with a diagnosis of Pneumonia. A review of the Transfer Order Sheet transcribed by the hospital physician, Medical Doctor (MD) #2, dated 11/07/11, revealed an order for oxygen at two liters (2 L) via nasal cannula to maintain an oxygen saturation (O2 sat) equal to or greater than 92%. Further orders included Albuterol 0.5% 2.5 milligrams (mg)=0.5 milliliters (ml) per nebulizer every six hours for shortness of air (SOA) or wheezing, and Ipratropium Bromide 0.02% 0.5 mg=2.5 ml per nebulizer every six hours for SOA or wheezing. A phone interview with MD #2, on 11/15/11 at 1:50 PM, revealed she wrote the discharge orders to the facility. She revealed the oxygen order was continuous to maintain O2 sats, as specified. The order was not "as needed."</p> <p>A review of the nurse's notes, dated 11/07/11 at 5:35 PM, revealed the resident had no signs or symptoms of distress on admission, and the resident's O2 sat was 92%.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 11/14/11 at 2:20 PM, 11/15/11 at 4:35 PM, and 11/18/11 at 8:45 AM, revealed she was the admitting nurse for Resident #1, on 11/07/11. She revealed the resident's O2 sat was 92%, and oxygen was not administered per the order. She stated "He/she was in no distress, and that was my nursing judgement." She revealed a report was given to Registered Nurse (RN) #1 at 6:00 PM, and she was made aware of the resident's</p>	F 224			

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F 224	<p>Continued From page 7</p> <p>need for an oxygen and nebulizer machine in the room.</p> <p>A review of the "Delivery Sheet" from Bluegrass Long Term Care Pharmacy, dated 11/07/11 at 8:21 PM, revealed the resident's nebulizer medications were delivered at this time and received by RN #1. A review of the Treatment Record, dated 11/07/11 at 9:00 PM, revealed the resident's O2 sat was 94%. A nebulizer treatment was due at this time, but had been initialed and circled on the record by RN #1, as not given. Review of the Treatment Record, dated 11/07/11 at 11:30 PM, revealed an O2 sat of 96%. On 11/08/11 at 1:24 AM, revealed an O2 sat of 93%. Review of the Nurse's Notes, on 11/08/11 at 1:24 AM, revealed the resident was in no acute distress. The Treatment Record, dated 11/08/11 at 3:00 AM, revealed a nebulizer treatment was due at this time, but was initialed and circled on the record by RN #1, as not given. On 11/08/11 at 4:00 AM, the Treatment Record revealed an O2 sat of 92%, and 93% on 11/08/11 at 4:45 AM.</p> <p>A phone interview with RN #1, on 11/14/11 at 3:00 PM and 5:00 PM, and on 11/16/11 at 1:50 PM, revealed she did not administer the resident's nebulizer treatments as ordered, as she could not find a nebulizer machine. She further revealed a part to the oxygen tank was missing, and she could not administer the oxygen as ordered. RN #1 revealed she could have called the pharmacy for a replacement part to the oxygen concentrator, but felt the resident did not need the oxygen. She revealed the resident's O2 sats were between 92-96% during the night.</p> <p>A phone interview with Nurse Aide (NA) #2, on</p>	F 224		

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F 224	<p>Continued From page 8</p> <p>11/14/11 at 12:25 PM, revealed she was responsible for the resident's care on 11/08/11, starting at 6:00 AM. She revealed "sometime after 6:00 AM," she was in the resident's room and heard "rattling" in the resident's chest. She revealed the resident was pale in color. She provided incontinent care for the resident and put him/her back to bed. Afterwards, the resident was "not acting right" and not responding. RN #1 was made aware.</p> <p>A review of the nurse's notes, on 11/08/11 at 6:30 AM, revealed the facility assessed Resident #1 as unresponsive and cyanotic, with an O2 sat of 53% on room air. Oxygen was placed on the resident at this time, at six liters (6 L) per nasal cannula. Interview with RN #1, on 11/14/11 at 3:00 PM, revealed she had given the resident a nebulizer treatment at this time; however, there was no documented evidence that a nebulizer treatment was provided. The resident expired at 6:44 AM.</p> <p>A review of the Kentucky Certificate of Death for Resident #1, filed 11/16/11, revealed the immediate cause of death was Respiratory Failure due to or as a consequence of Pneumonia.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 11/15/11 at 11:15 AM, revealed oxygen should have been a priority for the resident to have an admission to the facility. The oxygen concentrators have a panel on the side to store the connector that RN #1 claimed was "missing." She revealed the connector was available, and RN #1 should have called someone for assistance. She further revealed</p>	F 224			

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F 224	<p>Continued From page 9</p> <p>there were two nebulizer machines in the storage room on 11/08/11. The resident should have received his/her nebulizer treatments, as ordered.</p> <p>An interview with the Director of Nursing (DON), on 11/17/11 at 10:00 AM, revealed she expected the nurse to assess the resident on admission, and start the oxygen. She also expected RN #1 to give the nebulizer treatments, per the order. She revealed the necessary medical equipment was available in the storage room on 11/08/11.</p> <p>A phone interview with the attending physician, MD #1, on 11/14/11 at 4:40 PM, revealed he expected staff to administer oxygen and nebulizer treatments to the resident, per the physician's orders. He revealed there was a potential for the resident's condition to worsen without treatment.</p> <p>Interview with the Administrator, on 11/17/11 at 3:45 PM, revealed during the investigation, neglect was suspected as RN #1 did not give Resident #1 scheduled nebulizer treatments. She stated the nurses interpreted the orders as "as needed" instead of continuous related to O2.</p> <p>*The facility implemented the following actions to correct the deficiency:</p> <ul style="list-style-type: none"> -RN #1 was placed on Administrative leave pending the outcome of the investigation. She was terminated 11/10/11. -Inservices for licensed staff was conducted by the Corporate Educator, on 11/08/11, covering abuse, neglect, and exploitation, following physician's orders, change in resident's condition, MD notification and withholding of services or 	F 224			

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F 224	<p>Continued From page 10 treatment.</p> <p>-Nebulizer treatment orders will require a co-sign of another staff member. Staff on duty was made aware and oncoming staff was made aware prior to their shift.</p> <p>-Licensed staff was inserviced, on 11/08/11, by Respiratory Therapist (RT) #2, related to oxygen delivery systems, nebulizer machines, bi-pap machines, etc.</p> <p>-All residents on oxygen and nebulizer treatments were reviewed by the DON and ADON, with no problems noted. Orders for oxygen were clarified by the attending physicians to be "as needed" or "continuous."</p> <p>-Residents receiving nebulizer treatments and oxygen would be monitored daily, starting 11/08/11, for one week by the DON, then weekly for four weeks, then quarterly ongoing</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Interview with the Administrator, on 11/17/11 at 3:45 PM, revealed RN #1 was placed on Administrative leave, on 11/08/11, until the investigation was completed. Interview with RN #1, on 11/14/11 at 3:00 PM, revealed she was terminated on 11/10/11.</p> <p>A review of the facility inservice conducted on 11/08/11, revealed all licensed staff were inserviced on abuse, neglect, and exploitation, following attending physician orders, change in residents condition or status, MD notification of</p>	F 224			

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F 224	Continued From page 11 withholding of any services or treatment, oxygen setup, and nebulizer treatments. Review of the facility inservice on 11/08/11, with LPN #2, on 11/16/11 at 12:50 PM; LPN #1, on 11/16/11 at 12:00 PM; LPN #5, on 11/16/11 at 12:30 PM; LPN #3, on 11/16/11 at 2:20 PM; and RN #2, on 11/16/11 at 1:15 PM, revealed they had been inserviced on the above policies. Interview with the Corporate Educator, on 11/17/11 at 8:00 AM, revealed licensed staff were inserviced regarding clarification of oxygen orders related to "continuous" versus "as needed." Record review of three residents' treatment records revealed a staff member was co-signing on nebulizer treatments given. An observation of a nebulizer treatment, on 11/15/11 at 1:40 PM, revealed a staff member co-signed with LPN #2. Interview with licensed staff members revealed they were aware nebulizer treatments required a co-sign from another staff member. An interview with the DON, on 11/17/11 at 11:30 AM, revealed resident's on oxygen and nebulizer treatments had been reviewed with no concerns. All oxygen orders were clarified as continuous or as needed. A review of seven residents oxygen orders were verified with no concerns. The DON was able to verify monitoring of oxygen and nebulizer treatments. She provided eight consecutive days (11/8-15/11) of monitoring with no concerns. Further interview revealed she would ensure the clarification of all oxygen orders.	F 224		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	<p>Continued From page 12 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Pharmacy Delivery Sheet, the Kentucky Certificate of Death, and review of Kentucky Revised Statute (KRS) 314.011, it was determined the facility failed to ensure staff provided services that met professional standards of quality for one of four sampled residents (Resident #1). On 11/07/11 at 5:35 PM, Resident #1 was readmitted to the facility with a diagnosis of Pneumonia. Two facility staff failed to provide oxygen and two nebulizer treatments, per the physician's orders. Resident #1 was found at 6:30 AM on 11/08/11, unresponsive and cyanotic with an Oxygen saturation of 53 percent on room air. Resident #1 expired at the facility, on 11/08/11 at 6:44 AM, related to Respiratory Failure due to Pneumonia. (Refer to F224)</p> <p>The failure to provide treatment for a resident has caused, or is likely to cause serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. The Immediate Jeopardy was determined to exist on 11/07/11 through 11/08/11. The facility implemented corrective actions which were completed prior to the State Agency's investigation, on 11/18/11, and as a result, Past Jeopardy was determined. The Immediate Jeopardy was determined to be corrected on 11/09/11.</p> <p>Findings include: Review of KRS 314.011 revealed "Licensed</p>	F 281	Past noncompliance: no plan of correction required.	

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F 281	<p>Continued From page 13</p> <p>Practical Nursing practice" means the performance of acts requiring knowledge and skill such as are taught or acquired in approved schools for practical nursing in: c) The administration of medication or treatment as authorized by a physician, physician assistant, dentist, or advanced practice registered nurse.</p> <p>Further review of KRS 314.011 revealed "Registered Nursing practice" means the performance of acts requiring substantial specialized knowledge, judgement, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in: c) The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced practice registered nurse. Components of medication administration include but are not limited to: 1. Preparing and giving medications in the prescribed dosage, route, and frequency.</p> <p>A record review revealed Resident #1 was readmitted to the facility on 11/07/11 at 5:35 PM, with a diagnosis of Pneumonia. A review of the Transfer Order Sheet transcribed by the hospital physician, Medical Doctor (MD) #2, dated 11/07/11, revealed an order for oxygen at two liters (2 L) via nasal cannula to maintain an oxygen saturation (O2 sat) equal to or greater than 92%. A phone interview with MD #2, on 11/15/11 at 1:50 PM, revealed the oxygen order was continuous to maintain O2 sats, as specified. The order was not "as needed." Further orders, per the Transfer Order Sheet, included Albuterol 0.5% 2.5 milligrams (mg)=0.5 milliliters (ml) per nebulizer every six hours for shortness of air</p>	F 281			

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F 281	<p>Continued From page 14</p> <p>(SOA) or wheezing and Ipratropium Bromide 0.02% 0.5 mg=2.5 ml per nebulizer every six hours for SOA or wheezing.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 11/14/11 at 2:20 PM, 11/15/11 at 4:35 PM, and 11/18/11 at 8:45 AM, revealed she was the admitting nurse for Resident #1, on 11/07/11. She stated that oxygen was not administered on admission, per the order. She revealed the oxygen was not necessary at the time, as the resident's O2 sat was 92%. A report was given to Registered Nurse #1 at 6:00 PM, and she was made aware of the resident's oxygen and nebulizer treatment orders.</p> <p>A review of the "Delivery Sheet" from Bluegrass Long Term Care Pharmacy, dated 11/07/11 at 8:21 PM, revealed the resident's nebulizer medications were delivered at this time and received by RN #1. A review of the Treatment Record, dated 11/07/11 at 9:00 PM, and 11/08/11 at 3:00 AM, revealed a nebulizer treatment was due at these times, but both had been initialed and circled on the record by RN #1, as not given.</p> <p>A phone interview with RN #1, on 11/14/11 at 3:00 PM and 5:00 PM and 11/16/11 at 1:50 PM, revealed she did not administer the resident's nebulizer treatments as ordered. While RN #1 stated there were no nebulizer machines or O2 tanks with all the necessary equipment available, the facility's investigation per interview with the ADON revealed there were two nebulizers available and the O2 tanks had all necessary equipment available on 11/08/11. RN #1 revealed she could have called the pharmacy for a replacement part to the O2 concentrator, but felt</p>	F 281			

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F 281	<p>Continued From page 15 the resident did not need the O2.</p> <p>A review of the nurse's notes, on 11/08/11 at 6:30 AM, revealed the facility assessed Resident #1 as unresponsive and cyanotic, with an O2 sat of 53% on room air. Oxygen was placed at this time, at six liters (6 L) per nasal cannula. Interview with RN #1, on 11/14/11 at 3:00 PM, revealed she had given the resident a nebulizer treatment at this time; however, there was no documented evidence that a nebulizer treatment was provided. The resident expired at 6:44 AM.</p> <p>A review of the Kentucky Certificate of Death for Resident #1, filed 11/16/11, revealed the immediate cause of death was Respiratory Failure due to or as a consequence of Pneumonia.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 11/15/11 at 11:15 AM, revealed oxygen should have been a priority for the resident to have upon admission and the resident should have received his/her nebulizer treatments, as ordered.</p> <p>An interview with the Director of Nursing (DON), on 11/17/11 at 10:00 AM, revealed she expected the nurse to assess the resident on admission, start the oxygen and for the RN to give the nebulizer treatments, per the order.</p> <p>A phone interview with the attending physician, MD #1, on 11/14/11 at 4:40 PM, revealed he expected staff to administer oxygen and nebulizer treatments to the resident, per the physician's orders. He stated failure to provide these treatments creates a potential for the resident's</p>	F 281		

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F 281	<p>Continued From page 16 condition to worsen.</p> <p>*The facility implemented the following actions to correct the deficiency:</p> <ul style="list-style-type: none"> -RN #1 was placed on Administrative leave pending the outcome of the investigation. She was terminated 11/10/11. -Inservices for licensed staff was conducted by the Corporate Educator, on 11/08/11, related to following physician's orders and MD notification of withholding of any services or treatment. -Nebulizer treatment orders will require a co-sign of another staff member. Staff on duty was made aware and oncoming staff was made aware prior to their shift. -Licensed staff was inserviced, 11/08/11, by Respiratory Therapist (RT) #2, related to oxygen delivery systems, nebulizer machines, bi-pap machines, etc. -All residents on oxygen and nebulizer treatments were reviewed by the DON and ADON, with no problems noted. Orders for oxygen were clarified by the attending physicians to be "as needed" or "continuous." -Residents receiving nebulizer treatments and oxygen would be monitored daily, starting 11/08/11, for one week by the DON, then weekly for four weeks, then quarterly ongoing. <p>**The surveyor validated the corrective action taken by the facility as follows:</p>	F 281			

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F 281	<p>Continued From page 17</p> <p>Interview with the Administrator, on 11/17/11 at 3:45 PM, revealed RN #1 was placed on Administrative leave, 11/08/11, until the investigation was completed. Interview with RN #1, on 11/14/11 at 3:00 PM, revealed she was terminated 11/10/11.</p> <p>A review of the facility inservice conducted on 11/08/11, with licensed staff, revealed these staff members were inserviced on following attending physician orders, MD notification of withholding any services or treatment, oxygen setup, and nebulizer treatments. Review of the facility inservice on 11/08/11, with LPN #2, on 11/16/11 at 12:50 PM; LPN #1, on 11/16/11 at 12:00 PM; LPN #5, on 11/16/11 at 12:30 PM; LPN #3, on 11/16/11 at 2:20 PM; and RN #2, on 11/16/11 at 1:15 PM, revealed they had been inserviced on the above policies.</p> <p>Record review of three residents' treatment records revealed a staff member was co-signing on nebulizer treatments given. An observation of a nebulizer treatment, on 11/15/11 at 1:40 PM, revealed a staff member co-signed with LPN #2. Interview with licensed staff members revealed they were aware nebulizer treatments required a co-sign from another staff member.</p> <p>An interview with the DON, on 11/17/11 at 11:30 AM, revealed resident's on oxygen and nebulizer treatments had been reviewed with no concerns. All oxygen orders were clarified as continuous or as needed. A review of seven residents' oxygen orders were verified with no concerns. The DON was able to verify monitoring of oxygen and nebulizer treatments. She provided eight consecutive days (11/8-15/11) of monitoring with</p>	F 281			

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F 281	Continued From page 18 no concerns.	F 281		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure one of three sampled residents (Resident #3), received proper services for percutaneous endoscopic gastrostomy tube (PEG Tube). Observation of a water flush instilled into a PEG Tube, on 11/17/11, revealed the nurse did not verify placement of the PEG Tube prior to the instillation of the water. Findings include: A review of the facility's policy and procedure "Verifying Tube Placement (N-14(a)," undated, revealed the licensed nurse was responsible to ensure the tube is positioned in the desired site and to ensure the tube remains in the intended position before administration of formula or medications through the tube. A record review revealed Resident #3 was admitted to the facility on 03/28/11 with diagnoses	F 322	F 322 1. Corrective action: Resident # 3 Administering nurse was re-educated by the ADON immediately upon notification of the observation of the water flush being given without prior verification of tube placement. Treatment Administration Record (TAR) changed to include verifying and documenting tube placement <u>before</u> administering flushes, feeding or medications. Licensed staff inserviced on TAR changes and the proper care of a PEG tube by the DON on 11-21-11 including water flushes. 2. ID of others at risk: All residents with tube feedings and their TAR were reviewed by the DON/ADON 12-8-11 and 12-9-11. No problems were determined. 3. Prevention measures: Treatment Administration Record (TAR) changed to direct licensed staff to include verifying and documenting tube placement <u>before</u> administering flushes, feeding or medications. Licensed staff inserviced on TAR changes and the proper care of a PEG tube by the DON on 11-21-11 including water flushes.	

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F 322	<p>Continued From page 19</p> <p>to include Anoxic Brain Injury, Tracheostomy, Acute and Chronic Respiratory Failure, Gastrostomy and Respiratory Abnormality. The resident was totally dependent on staff for all care and all nourishment and fluids were via percutaneous endoscopic gastrostomy tube (PEG Tube). Further review of Resident #3's record revealed a physician's order, dated November 2011, to "flush PEG with 200 milliliters (ml) of water every four hours."</p> <p>An observation, on 11/17/11 at 12:25 PM, revealed Licensed Practical Nurse (LPN) #4 administered 240 cc's of water into Resident #3's PEG Tube, without verification of placement of the PEG Tube. LPN #4 turned the feeding pump off, inserted an Asepto syringe into the PEG Tube and poured some of the water into the Asepto syringe. The remaining water was added to the Asepto syringe until all the water had been instilled into the PEG Tube. LPN #4 did not verify the correct placement of the PEG Tube at anytime during this procedure.</p> <p>An interview with LPN #4, immediately following the procedure, revealed she did not check placement each time she instilled water or medication into the PEG Tube. She only checked residual and placement in the mornings. LPN #4 was unable to verify the facility policy and procedure for checking placement of PEG Tubes.</p> <p>An interview with the Director of Nursing (DON), on 11/17/11 at 2:08 PM, revealed she would not instill anything into a PEG Tube without first checking placement and expected any nurse to check placement first.</p>	F 322	<p>4. Monitor:</p> <p>All residents with a PEG tube are checked each shift and are being specifically re-checked weekly by the DON for any PEG tube issues along with a review of the TAR for documentation of placement verification. Any adverse issues are corrected immediately and findings reported through the facility CQI x 3 months and then quarterly x 12 months.</p> <p>Date Corrected:</p>	12-10-11	