

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

PRINTED: 01/30/2012  
FORM APPROVED  
OMB NO. 0938-0391

#16472

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/13/2012
NAME OF PROVIDER OR SUPPLIER  BARREN COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141	
(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 (KY #16472, KY #16669, KY #17570, KY #17288 and #16707) was initiated on 01/11/12 and concluded on 01/13/12. KY #16472 and KY #16669 were substantiated with deficiencies cited at the highest scope and severity of a "D." KY #17570 and KY #16707 were substantiated with no deficiencies cited. KY #17288 was unsubstantiated with no deficiencies cited.	F 000		
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	F 157	F 157 Notify of Changes (injury/Decline/Room, Etc.)  Criteria 1: Resident #1 is no longer a resident at the facility.  Criteria 2: The last 30 days of accu check documentation have been reviewed by the DON and ADON on 2/3/12 to determine that any results outside the physician ordered parameters have been reviewed with the attending physician.  Criteria 3: Licensed nursing staff have received inservice education on resident change in condition criteria requiring MD notification including but not limited to abnormal blood glucose levels outside MD established parameters as provided by the DON and/or Staff Development Coordinator	



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

*Steve Brown*

TITLE

*N.H.H.*

(X6) DATE

*2-16-2012*

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 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> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure physician notification and/or family notification due to a change in condition for one resident (#1), in the selected sample of ten residents. Resident #1 experienced a blood glucose reading of 30 mg/dl, necessitating administration of an injection to increase the resident's blood sugar (BS) level.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Physician/ Responsible Party Notification," dated 10/23/09, revealed "nursing staff were to consult with the resident's physician, the resident's legal representative or an interested family member, when there was an accident involving the resident which results in injury and has the potential for requiring physician intervention (i.e. a fall or event resulting in adverse effects on the physical status and/or vital signs of the resident); when there is a significant change in the resident's physical, mental or psychosocial status in either life threatening conditions or clinical complications; when there is a need to alter an existing treatment significantly (i.e. needed to discontinue an existing form of treatment due to adverse consequences), in non-critical situations (those</p>	F 157	<p>F 157 Continued: Criteria 3: by 2/17/12.</p> <p>Criteria 4: The CQI indicator for the monitoring of MD notification will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5: February 18, 2012.</p>		

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F 157	<p>Continued From page 2</p> <p>not involving hospitalization or other immediate interventions), the legal representative was to be notified immediately unless otherwise indicated on a 'Notification Request Form.' All notifications and/or attempted notifications were to be documented in the nursing notes."</p> <p>A record review revealed Resident #1 was admitted to the facility on 04/15/11 with diagnoses to include Diabetes, Chronic Renal Failure Stage III, Urinary Tract Infection (UTI) and Coronary Artery Disease.</p> <p>A review of the admission Minimum Data Set (MDS), dated 04/22/11, revealed the facility identified Resident #1 to be severely cognitively impaired, alert/oriented to name only and to "recognize family." Further review revealed the resident required extensive assistance of two staff members with all activities of daily living (ADLs). The resident was continent of bowel; however, he/she experienced occasional bladder incontinence. The resident was resistive to care, refusing multiple interventions during care with behaviors of hitting, kicking and biting staff members.</p> <p>Further record review revealed he/she was care planned to be at risk for falls, dated 04/15/11, and at risk for skin break down, dated 04/15/11, due to Diabetes, skin tears and bruising. A review of a care plan for "Behaviors," dated 04/29/11, revealed the potential of self-injury during provision of care due to cognitive deficits. Further review of the care plans, "At Risk for Skin Breakdown, Potential for Injury, Alteration in Nutrition related to Diabetes and At risk for Falls," revealed interventions included for staff members</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>to notify the nurse if the resident fell, had a poor appetite, and for behaviors of striking out at staff members. Additional care plan review revealed the physician was to be notified, as needed, with any complaints of pain not relieved with an as needed (PRN) pain medication.</p> <p>A review of the physician's orders, dated May 2011, revealed "accuchecks (used to determine BS levels) before meals and at bedtime. If greater than or equal to 500 mg/dl, call the physician."</p> <p>An interview with Registered Nurse (RN) #1, on 01/12/12 at 10:45 AM, revealed, on 05/20/11 at 7:40 AM, Resident #1's BS reading was 32 mg/dl and the resident was observed to be "lethargic." At 7:50 AM, an injection was administered to the resident for the low BS reading. The resident remained lethargic with a BS reading of 40 mg/dl. At 8:05 AM, the resident's BS reading was 71 mg/dl and the resident was "crying, talking and hitting at staff" at that time. At 8:15 AM, a fax was sent to the physician. At 8:25 AM, the resident's daughter was notified to see if she could come to the facility and try to get the resident to eat breakfast. It was 10:30 AM before the physician responded by fax with no further orders received.</p> <p>Further interview with RN #1 revealed, that on 05/22/11 at 4:30 PM, Resident #1's BS reading was 40 mg/dl. The resident was difficult to arouse, but "slapped" at the nurse when his/her finger was pricked. An injection was administered to the outer right arm, and the nurse waited 15 minutes, then rechecked the BS for a reading of 63 mg/dl. At that time, the resident was talkative and responsive. The physician was</p>	F 157			

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F 157	Continued From page 4 not notified, and the family was not made aware until they arrived at the facility at 7:30 PM, for a visit. RN #1 stated she would have contacted the physician had the resident not responded to the injection. The RN stated the resident had a history of widely fluctuating BSs and the physician was aware of the resident's history.  An interview with the Director of Nursing (DON), on 01/12/12 at 10:03 AM, revealed she did not expect the nurses to notify the physician "or a family member at midnight for a skin tear, but maybe a fall." She stated she did not recall if she was made aware of the resident's low BS, and was unaware of whether or not the physician was notified. She revealed she was unable to locate any evidence of physician notification in the resident's clinical record.	F 157			
F 226 SS=D	<b>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</b>  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 interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents for one resident (#3), in the selected sample of ten residents. It was alleged that Certified Nurse Aide (CNA)/Nurse Technician (NT) #1 and #2, on 06/09/11, left the resident on the toilet, unattended, which resulted	F 226	<b>F 226 Develop/Impliment Abuse/Neglect, Etc. Policies</b>  Criteria 1: Resident #3 is not left unattended while toileting.  Criteria 2: Facility residents that are on the fall prevention program are not left unattended while toileting.  Criteria 3: Facility nursing staff have received inservice education on resident toiletting assistance, including but not limited to the need for staff to be in accordance with facility policy; and the		

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F 226	<p>Continued From page 5</p> <p>in a fall with a fracture. CNA/NT #1 and #2 were suspended from work and an investigation was initiated.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Initial Fall Management Intervention Alternatives," undated, revealed the staff members "were not to leave the residents up in the room or on the commode unattended."</p> <p>A record review revealed Resident #3 was admitted to the facility on 05/17/11 with diagnoses to include Alzheimer's Dementia, Anxiety and Neuropathy.</p> <p>A review of the care plan for falls, dated 05/19/11, revealed the resident required a sensory alarm on the bed, non-skid socks at bedtime, and staff were to observe for any attempts of the resident getting up unassisted.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 10/30/11, revealed the resident to be severely cognitively impaired and required extensive assistance of two staff members for transfers/bed mobility and was occasionally incontinent of bowel and bladder.</p> <p>An observation of Resident #3's room, on 01/11/12 at 12:55 PM, revealed colored dot stickers on the resident's doorway and on the headboard of the resident's bed, indicating the resident was a falls risk. The resident was alert and seated in a wheel chair in the dining area finishing his/her noon meal. The resident had not expressed knowledge of the fall and stated</p>	F 226	<p>F 226 Criteria 3 Continued: disciplinary action which will be implemented for failure to provide this assistance as per facility policy, as provided by the DON and/or Staff Development Coordinator by 2/17/12.</p> <p>Criteria 4: The CQI indicator for the monitoring of provision of the residents assistance in accordance with facility policy will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5: February 18, 2012.</p>		

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F 226	<p>Continued From page 6 he/she just arrived at the facility.</p> <p>An interview with CNA/NT #1, on 01/13/12 at 2:38 PM, revealed Resident #3 was not on a falls prevention program at the time of the fall and did not have a "green dot" on the doorway. The CNA/NT stated if Resident #3 used the call light, the staff members were to answer immediately. The CNA/NT stated she felt, "at the time it was all right to leave the resident alone on the toilet" because she did not have a green dot on the door, and felt he/she needed more time and some privacy.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/12/12 at 2:13 PM, revealed CNAs/NTs #1 and #2 were interviewed, separately, and both stated when Resident #3's call light alarmed, they left to answer the call light and both were told the resident needed immediate response. The LPN stated the resident had no previous attempts of self-transfers or falls. The LPN did not recall if the resident had a green sticker on the doorway to indicate a falls risk. She stated that was usually completed upon admission, and the facility's policy/procedure revealed that no one was to be left unattended on the toilet.</p> <p>An interview with the Director of Nursing (DON), on 01/13/12 at 3:18 PM, revealed it was the facility's policy/procedure that a resident was never to be left unattended on the toilet.</p>	F 226			