

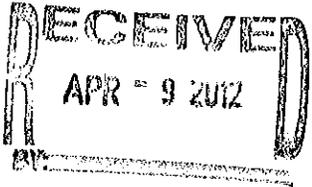
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2012
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NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071
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<p>F 000</p> <p>F 241 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted 03/13/12 through 03/16/12. Deficiencies were cited with the highest Scope and Severity of a "D".</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Employee Handbook, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one unsampled resident (Unsampled Resident A). This was evidenced by verbal communication about Unsampled Resident A's medical condition spoken by a Hospice Nurse to the facility's Chaplain while standing near Elevator #1 where Unsampled Resident B was positioned.</p> <p>The findings include:</p> <p>Review of the facility's Employee Handbook section 3.4. [Health Insurance Portability and Accountability Act (HIPPA)], undated, revealed the facility adheres to privacy standards in protecting health care information. further review of section 3.5. (Confidentiality) revealed</p>	<p>F 000</p> <p>F 241</p>	<p>Preparation or execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed, as required by the provision of federal and state law.</p> <p>F 241 - Dignity</p> <p>The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <ol style="list-style-type: none"> The hospice contractor was notified of the violation and consequences. The nurse from hospice that was involved was replaced and will not be allowed to provide services in the building. Hospice was requested to educate all of their staff about confidentiality and respect. A full house inservice was done for the hospice staff. (Attachment F 241A.) All residents living in the facility have the potential to be affected by the deficient practice. 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sonna Frodge RN LNHA</i>	TITLE <i>Administrator</i>	(X8) DATE <i>4/6/12</i>
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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 241	<p>Continued From page 1</p> <p>confidentiality is a fundamental aspect of all health care services.</p> <p>Observation, on 03/16/12 at 9:10 AM, near elevator #1 on the ground floor of the facility, revealed a Hospice Nurse initiated a conversation regarding Unsamped Resident A's medical condition with the facility's Chaplain with Unsamped Resident B seated nearby. The conversation included information related to Unsamped Resident A when the Hospice Nurse stated Unsamped Resident A "was actively dying".</p> <p>Interview with the Hospice Nurse, 03/16/12 at 9:11 AM, revealed she was initially unaware her conversation could be heard by two (2) persons. She further stated she had not identified the resident by name but had only discussed a change in the resident's medical condition. However, continued interview revealed she had identified the resident by name and disclosed inappropriate information which had been overheard.</p> <p>Interview with the facility's Chaplain, on 03/16/12 at 10:00 AM, revealed he was aware two (2) people could hear the conversation. He stated the facility had encouraged Hospice to communicate regarding residents' conditions but thought the nurse "just wasn't thinking about who was around when she spoke". Continued interview revealed the content of the information the Hospice Nurse had shared regarding Unsamped Resident A was inappropriate, given the audience that was within hearing distance.</p> <p>Interview with the Administrator, on 03/16/12 at</p>	F 241	<p>3. a. The Assistant Director of Nursing provided staff reeducation to all employees in all departments as to privacy standards in protecting health information. Nursing staff used from the staffing agency were included in the education. The Director of the staffing agency was also informed and requested to continue to stress confidentiality in all new hire orientation.</p> <p>b. Copies of the Employee Handbook, section 3.4 and 3.5, with a quiz that had to be answered and returned to the DON/Department head were distributed with the paychecks on 4/5/2012. Once reviewed, these signed quizzes will be placed in the employee file (Attachments F 241 B</p> <p>c. HIPAA agreements were mailed to service contractors who have access to patient information. This is an updated agreement that will also be placed in contractor's files. These included lab, portable x-ray, pharmacy, dietary consultant, hospice and oxygen supplier. These agreements are to be signed and returned to the facility. (Attachment F 241 C.)</p>	

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<p>F 241</p> <p>F 279 SS=D</p>	<p>Continued From page 2</p> <p>10:05 AM, revealed the conversation between the Hospice Nurse and the Chaplin in front of the elevator was not tolerated and not the standard practice of the facility.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to develop a Comprehensive Care Plan based on the residents' Comprehensive Assessment, which included measurable objectives and individual</p>	<p>F 241</p> <p>F 279</p>	<p>d. Colorful signs have been posted in nursing stations, work areas and near the time clock to remind employees to maintain confidentiality of residents' information. (Attachment F 241 D.)</p> <p>4. Staff is reminded to report any breach of confidentiality to a manager. All staff members are responsible for maintaining and reminding others of the importance of enhancing resident dignity and respect. Any reported infractions to department heads or administrator will be immediately investigated and addressed by the administrator.</p> <p>F 279</p> <p>Develop Comprehensive Care Plans</p> <ol style="list-style-type: none"> 1. Resident # 17's care plan was updated to include assessed dental issues and interventions on 3/18/2012 2. Twenty additional residents in this home triggered the dental CAA. All 20 charts, CAA's and care plans were reviewed by 3/21 and found to be compliant 	<p>F 241</p> <p>4/6/2012</p>

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F 279	<p>Continued From page 3</p> <p>interventions to meet resident needs for one (1) of twenty-five (25) sampled residents (Resident #17).</p> <p>The findings include:</p> <p>Review of the facility's "Comprehensive Resident Assessment" policy, undated revealed the information obtained through the Minimum Data Set (MDS) and the Care Area Assessment (CAA) will be used as the foundation for the development of the Comprehensive Care Plan.</p> <p>Observation on 03/16/12 at 8:45 AM revealed the resident to have broken teeth.</p> <p>Review of Resident #17's medical record revealed an admission date of 01/20/12 and diagnoses which included Cerebrovascular Accident (CVA) with left sided weakness. Review of the Admission MDS Assessment, dated 02/02/12, revealed the facility assessed the resident to have "obvious or likely cavity or broken natural teeth". Review of the CAAs revealed the area of Dental Care triggered and was to be addressed in the Comprehensive Care Plan. Further review of the CAAs revealed a care plan would be developed with a goal that the resident would remain free of oral pain and infection.</p> <p>Review of the Comprehensive Care Plan, dated 02/02/12, revealed no documented evidence of a Dental Care Plan. Further review revealed no documented evidence Resident #17's dental issues were addressed within the Comprehensive Care Plan.</p>	F 279	<p>F 279 continued</p> <p>3. a. On 3/21/2012, a facility specific practice note was added to the Comprehensive Resident Assessment policy. The MDS nurses were instructed to complete CAA specific care plans and no longer combine CAA problem areas. (Attachment F 279 #1)</p> <p>b. A standardized dental care plan that addresses real or potential dental problems and is easily personalized was added to the pre-printed care plan library for ease of accessibility by unit staff should a problem arise in between comprehensive assessments. (Attachment F 279 #2)</p> <p>4. A quarterly audit will be completed on all residents triggering a dental CAA in the previous 3 month. (Attachment F 279 #3) This audit will be done in July, October and January and reviewed at the January QA meeting (or sooner if problem are identified) The frequency of future audits will be determined at the January 2014 QA meeting</p>	<p>F 279</p> <p>4/6/2012</p>

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F 279	Continued From page 4 Interview, on 03/16/12 at 3:30 PM, with the Clinical Coordinator revealed Resident #17's dental issues should have been addressed in the Comprehensive Care Plan. She stated the Comprehensive Care Plan did not address the CAAs or the resident's dental needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs; and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of twenty-five (25) sampled residents (Resident #2).	F 280	F 280 Right to participate in Care Planning/Revise Care Plan 1. The care plan for Resident #2 was revised on 3/17/2012. The "Oxygen as ordered" statement was removed to reflect the current physician plan of care 2. All residents have the potential to be affected as all residents have a Nurse Aid Care Plan (NACP) initiated at the time of admission. All current residents NACP's were audited for accuracy and corrections made as needed, This was accomplished by 3/19 and the results reported at the QA meeting on 3/20/2012 3. a. The daily QA meeting which includes review of all admissions/readmissions was expanded to add review of the NACP. (Attachment F 280 #1) b. The Unit managers will be reviewing all NACP's on their respective units at least monthly within the first two weeks of the month.	

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F 280	Continued From page 5 The findings include: Review of Resident #2's medical record revealed the facility admitted the resident on 04/25/11 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). Review of the Comprehensive Respiratory Care Plan, dated 04/26/11, revealed an intervention for "oxygen as ordered". Review of the Potential for Altered Cardiac Output/Function problem on the Care Plan revealed an intervention to "administer oxygen as ordered". Further review of the record revealed no documented evidence of Resident #2 wearing oxygen from 01/01/12 through 03/15/12. Observation of Resident #2 from 03/13/12 through 03/15/12 revealed the resident had no oxygen in his/her room and was not wearing oxygen. Interview, on 03/15/12 at 2:55 PM, with Licensed Practical Nurse (LPN) #10 revealed Resident #2 used to wear oxygen, however no longer needed it. Interview, on 03/15/12 at 4:30 PM, with the Fourth Floor Unit Manager revealed oxygen use should no longer be on Resident #2's Comprehensive Care Plan as he/she no longer required oxygen use. Interview, on 03/16/12 at 3:30 PM, with the Clinical Coordinator revealed oxygen use should not be on Resident #2's Comprehensive Care Plan if he/she no longer required oxygen use.	F 280	F 280 Continued 4. A random audit of 15 NACP's (3 per unit) will be completed in the last 2 weeks of the month. (Attachment F 280 #2) The results of this audit will be reported at the monthly QA meeting. Progress will be evaluated at the quarterly meeting scheduled for August. The frequency of future audits will be determined at that time	F 280 4/6/2012
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 6 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 431	F 431 Drug Records 1. No specific resident was identified in this deficiency statement 2. There are five nursing units having the potential to be affected by this same deficient practice. 3. All nurses that are responsible for medication carts will ensure all drug records are in order and that an account of all controlled drugs is maintained and reconciled at the beginning and end of each shift. a. Education on proper documentation of nursing records with emphasis on the responsibility of accurate narcotic count documentation was provided between 3-19-2012 to 4-2-2012 for all staff having access to a medication cart. (Attachment F 431 #1) b. A new "Change of Shift Narcotic Count Sheet" was inserviced. This count sheet was initiated 4/1/2012 (Attachment F 431 #2)	

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F 431	<p>Continued From page 7</p> <p>the facility's policy, it was determined the facility failed to ensure all drug records were in order and that an account of all controlled drugs was maintained and reconciled per the facility's policy, when five (5) out of six (6) Narcotic Count Sheets were not signed at the end of each shift.</p> <p>The findings include:</p> <p>Review of the facility policy, titled "Schedule Drug Count", not dated, revealed after the supply of narcotics is counted and justified, each nurse must record the date and his/her signature verifying that the count is correct.</p> <p>Interview with the Director of Nursing (DON), on 03/16/12 at 3:00 PM, revealed at the end of the shift, staff was to count the controlled medications and sign the Controlled Substance count sheet. She further stated the Controlled Substance count sheets should not have had any blanks.</p> <p>Record review of the Controlled Substance count sheet on Unit Two (2) A, on 03/14/12 at 11:00 AM, revealed there was no staff signatures for the off going Nurse on 03/10/12 at 6:00 AM and 03/11/12 at 6:00 AM. Further review of the Controlled Substance count sheet on Unit Two (2), revealed there was no staff signatures for the oncoming Nurse on 03/10/12 at 10:00 PM.</p> <p>Record review of the Controlled Substance count sheet on Unit Three (3) A, on 03/14/12 at 11:00 AM, revealed there was no staff signatures for the off going Nurse on 03/13/12 at 10:00 PM. Further review of the Controlled Substance count sheet on Unit Three (3) A, revealed there was no staff</p>	F 431	<p>F 431 continued</p> <p>4. Monitoring of signatures will be completed via audit that will be conducted two times a week by the unit managers beginning on 3-15-2012. (attachment F 431 #3) These audits will be reviewed at the April 10th QA meeting. The frequency of future monitoring will be determined at that QA meeting, along with the need for additional education.</p>	<p>F 431</p> <p>4/6/2012</p>

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F 431	<p>Continued From page 8</p> <p>signatures for the oncoming Nurse on 03/10/12 at 10:00 PM and 03/11/12 at 6:00 PM.</p> <p>Record review of the Controlled Substance count sheet on Unit Four (4) A, on 03/14/12 at 11:00 AM, revealed there was no staff signatures for the off going Nurse on 02/17/12 at 10:00 PM, 02/21/12 at 10:00 PM, 02/23/12 at 10:00 PM, 02/24/12 at 2:00 PM, 02/24/12 at 10:00 PM, and 03/13/12 at 6:00 AM. Further review of the Controlled Substance count sheet on Unit Four (4) A, revealed there was no staff signature for the oncoming Nurse on 02/21/12 at 2:00 PM, 02/23/12 at 2:00 PM, 02/23/12 at 10:00 PM, 02/24/12 at 2:00 PM, 02/25/12 at 10:00 PM, 02/26/12 at 6:00 AM and 03/12/12 at 10:00 PM.</p> <p>Record review of the Controlled Substance count sheet on Unit Four (4) B, on 03/14/12 at 11:00 AM, revealed there was no staff signatures for the off going Nurse on 03/03/12 at 10:00 PM, 03/04/12 at 10:00 PM, 03/05/12 at 6:00 AM, 03/11/12 at 6:00 AM, 03/12/12 at 10:00 PM, and 03/13/12 at 10:00 PM. Further review of the Controlled Substance count sheet on Unit Four (4) B, revealed there was no staff signatures for the oncoming Nurse on 03/03/12 at 2:00 PM, 03/04/12 at 2:00 PM, 03/04/12 at 10:00 PM, 03/12/12 at 2:00 PM, and 03/13/12 at 10:00 PM.</p> <p>Interview with Registered Nurse (RN) #2, on 03/14/12 at 11:20 AM, revealed the oncoming Nurse was to count the controlled medications with the off going Nurse at the end of each shift and sign the Controlled Substance count sheet. He further stated the Controlled Substance count sheets should not have had any blanks.</p>	F 431		

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F 431	Continued From page 9 Interview with Licensed Practical Nurse (LPN) #2, on 03/14/12 at 12:20 PM, revealed staff was to sign the Controlled Substance count sheet after they counted the controlled medications and there should not have been any blanks of the Controlled Substance count sheet.	F 431		
F 463 SS=D	483.7.(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure all residents had a means of directly contacting caregivers for one (1) of twenty five (25) sampled residents (Resident #13). Observations on 03/13/12 and 03/15/12 revealed Resident #13's call light was out of reach on four (4) different observations. The findings include: Interview with the Director of Nursing (DON), on	F 463	F 463 Call System 1. Resident #13 will have a call light within reach at all times. 2. All residents have the potential to be affected by not having a call light within their reach.	

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NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071	
(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)	(X6) COMPLETION DATE
F 463	<p>Continued From page 10</p> <p>03/16/12 at 3:00 PM, revealed the facility followed the recommendations made by Mosby's Textbook for Long Term Care Nursing Assistants the Sixth Edition copyrighted 2007, which states the signal light was to be kept within the person's reach in the room, bathroom, and shower or tub room. Interview with Registered Nurse (RN) #2, on 03/14/12 at 3:00 PM, revealed the call light was to always be within reach of the resident.</p> <p>Record review revealed the facility admitted Resident #13 on 12/27/07, with diagnoses which included Alzheimer's Disease, Anxiety, and Sciatica. Review of the medical record, dated 09/16/10, revealed the facility developed a car Plan for Resident #13 for the use of a restraint, the Gerry chair, to be used to promote comfort and positioning with an intervention to keep the call light within reach. Review of the Annual Minimum Data Set (MDS) Assessment, dated 08/17/11, revealed the facility assessed the resident as having severe cognitive impairment.</p> <p>Observation, on 03/13/12 at 2:30 PM, 3:15 PM, and 4:30 PM, revealed Resident #13 was in his/her Gerry chair in his/her bed room sitting in front of the television; however, the call light was on the resident's bed across the room.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 03/13/12 at 4:35 PM, revealed she had changed Resident #13 earlier in the shift and had forgotten to move the call light from the bed to the Gerry chair, within the resident's reach. She further stated the call light should always be in reach of the resident, and Resident #13 was not able to reach his/her call light while in the Gerry chair.</p>	F 463	<p>F 463 continued</p> <p>3. Education referencing the proper placement of call lights within reach for all residents was conducted 3/19 through 4/2/2012. (Attachment F 463 #1) All nursing staff and Certified Nursing Assistants were included in this education. The facility follows recommendations made by Mosby's textbook for Long Term Care Nursing Assistants, the Sixth Edition copyrighted 2007, which states the signal light is to be kept within the person's reach, in the room, bathroom and shower or tub room.</p> <p>4. The Care Committee will do weekly audits for six weeks, beginning immediately. The audit results will be reviewed weekly with immediate corrective actions put in place, with a review of all of the audits at our May 8th QA Committee meeting. Further monitoring or the need for additional education will be determined at the May 8th QA meeting.</p>	F 463 4/6/2012

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F 463	Continued From page 11 Observation, on 03/15/12 at 2:00 PM, revealed Resident #13 was up in his/her Gerry chair sitting in front of the television while the call light was clipped to the bed, across the room from Resident #13. Interview with CNA #5, on 03/15/12 at 2:15 PM, revealed when Resident #13's spouse was with the resident, she would not always place the call light within reach of Resident #13 because the spouse would let staff know the resident's needs. Further interview revealed the call light should always be within reach of the resident and while Resident #13 was in the Gerry chair, he/she would not be able to reach the call light. Interview with the DON, on 03/16/12 at 3:00 PM, revealed the call light was to always be within reach of the resident, even if there was family in the resident's room. Further interview revealed Resident #13's call light should always be kept within reach any time he/she was in his/her room. Interview with the Administrator, on 03/16/12 at 3:30 PM, revealed the call light was to be in reach of all residents, any time they were in their room. Further interview revealed the call light should have been within reach of Resident #13 while he/she was in his/her room.	F 463			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514	F- 514 Resident Records- complete/accurate/accessible SEE NEXT PAGE		

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F 514	<p>Continued From page 12 systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Interview, record review and review of the facility's policy, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for one (1) of twenty five (25) sampled residents (Resident #4). This is evidenced by the facility's failure of licensed staff to document on Resident #4's Medication Administration Record (MAR), the administration of a PRN (as needed) pain medication on 02/07/12. In addition, staff failed to document on the Pain Assessment Flow Sheet for medications administered to Resident #4 on 02/06/12 and 02/07/12.</p> <p>The findings include: Review of the facility's policy, "Medication Administration-General Guidelines", revealed the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of the medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and</p>	F 514	<p>F- 514</p> <p>Resident Records- complete/accurate/accessible</p> <ol style="list-style-type: none"> 1) All Nurses and CMA's were inserviced on the use of the Pain Management Flow record. Between 3/19 and 4/2/2012 (attachment F-514 # 1) 2) All residents receiving PRN medications have the potential to be affected. 3) a. Records were audited to identify omissions in documentation b. The pharmacy procedure manual section "Preparations and General Guidelines" subsection "Documentation" was updated to clarify that all PRN pain medications are to be monitored on the PAIN MANAGEMENT FLOW SHEET and not on the back of the MAR (attachment F-514 # 2) c. The PAIN MANAGEMENT PROTOCOL was updated to clarify that the document is to be used only for PRN pain medications (attachment F-514 # 3a & 3b) 	

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F 514	<p>Continued From page 13</p> <p>documented. In no case should the individual who administers the medications report off-duty without first recording the administration of any medications. The policy further stated, when PRN medications are administered, the following documentation is provided: Date and time of administration, dose, route of administration (if other than oral); Complaints or symptoms for which the medication was given; Results achieved from giving the dose and the time results were noted; Signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication.</p> <p>Review of the facility policy, "Pain Management Protocol", revised date 01/2011, stated the Pain Management Flow Sheet will be utilized to assess the effectiveness of the pain medication regime to assure optimal pain management.</p> <p>Record review revealed the facility admitted Resident #4 on 01/24/12, with diagnoses which included Arthritis, Fracture and Orthopedic Aftercare, Osteoarthritis, and Cellulitis.</p> <p>Review of Resident #4's Physician's Orders, dated 01/25/12, revealed Tylenol one (1) tablet as needed for pain every four (4) hours. Record review of the Nurses' Notes, dated 02/07/12 at 3:00 AM, revealed Resident #4 complained of leg pain and PRN Tylenol was given as ordered. However, there was no documentation on the MAR to indicate the medication had been administered. In addition there was no documented evidence on the Pain Assessment Flow Sheet regarding the complaint of pain symptoms or the results achieved as directed by</p>	F 514	<p>F 514 continued</p> <p>4) The unit managers are responsible for monitoring the records for omissions 2 times per week (attachment F-514 # 4) The results of these audits will be reviewed at the QA meeting on April 10th. The frequency of ongoing monitoring will be determined at that time.</p>	<p>F 514</p> <p>4/5/2012</p>

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F 514	<p>Continued From page 14 the facility's policy.</p> <p>Continued review of the MAR for 02/12 revealed Resident #4 received the medication on 02/07/12 at 3:50 PM. However, there was no documented evidence per the facility's policy documenting the complaints or symptoms for which the medication was given, results achieved from the dose and the time results were noted.</p> <p>Record review of the Nurses' Notes, dated 02/07/12 at 8:00 PM, revealed Resident #4 complained of leg pain and received pain medications. Continued review of the record revealed at 10:00 PM the resident was "crying in pain...Tylenol not working...". Further review of the record revealed Resident #4 received additional pain medication as ordered at 11:00 PM. However, there was no documented evidence on the Pain Assessment Flow Sheet, per the facility's policy, which documented the complaints or symptoms for which the medication was given, results achieved from the dose and/or the time results from the medication were noted.</p> <p>Interview, on 03/15/12 at 2:30 PM, with Licensed Practical Nurse (LPN) #7, who was assigned to provide care for Resident #4 on 02/07/12, revealed she was only the nurse who charted Resident #4 received the medications in the Nurses' Notes. She was the "desk nurse" not the "person passing medications".</p> <p>Interview with LPN #9, on 03/16/12 at 10:40 AM, revealed she had administered medications to Resident #4 for pain relief and was aware that the Pain Management Flow Sheet should have been utilized to assess the effectiveness of the pain</p>	F 514		

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F 514	<p>Continued From page 15</p> <p>medication regime by documenting the complaint and symptoms of pain, including interventions and relief outcome. Further interview revealed she could not recall why she had failed to document on the Pain Management Flow Sheet after administering PRN medications to Resident #4.</p> <p>Interview with the Director of Nursing, on 03/16/12 at 10:20 AM, revealed the MAR should have been completed when medication was administered as ordered. In addition, the Pain Assessment Flow Sheet should have been completed when the PRN medication was administered to Resident #4. The documented information on the Flow Sheet should have included the date/time, pre-medication scored pain rating with location of the resident's pain, all interventions and the response.</p>	F 514		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1948, 1967, 1989</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type I fire resistive construction</p> <p>Smoke Compartment: twenty one (21)</p> <p>Fire Alarm: Complete Fire alarm A Building: Smoke detectors in resident rooms/ Heat detectors in corridors B Building: Smoke detectors in resident rooms/ Heat detectors in corridors C Building: Single station Smoke Detectors in resident rooms/ Smoke detectors in corridors.</p> <p>Sprinkler System: Complete sprinkler system (wet)</p> <p>Generator: A Building: Diesel installed 1989 C Building: Diesel installed 1989</p> <p>A standard Life Safety Code survey was conducted on 03/14/12. Baptist Convalescent Center was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred sixty three (163). The facility is licensed for one hundred sixty seven (167).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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