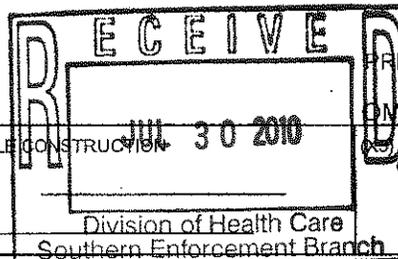


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Division of Health Care Southern Enforcement Branch	DATE SURVEY COMPLETED  07/07/2010
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NAME OF PROVIDER OR SUPPLIER  EPHRAIM MCDOWELL REGIONAL MEDICAL CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 217 SOUTH THIRD STREET DANVILLE, KY 40422
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(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	F 000		
F 281 SS=D	<p>A standard health survey was conducted on July 6-7, 2010. Deficient practice was identified with the highest scope and severity at an "E" level.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services were provided and care was delivered in accordance with professional standards of quality for one (1) of ten (10) sampled residents (resident #1). Resident #1 was admitted to the facility with an indwelling catheter; however, the facility failed to develop an interim care plan related to the indwelling catheter and the care required.</p> <p>The findings include: Review of the medical record revealed resident #1 was admitted to the facility on July 2, 2010, with the diagnoses of right hip fracture that required surgical intervention and urinary retention requiring an indwelling catheter. Resident #1 had been a resident at the facility for four days; therefore, a full assessment had not been completed. Review of the interim care plan developed upon the resident's admission to the facility revealed the care plan failed to address that resident #1 was admitted with an indwelling catheter.</p>	F 281	<p>Professional standards of quality for developing interim care plans for indwelling catheters has been placed on the "TCU Admission Checklist" to prevent omission. See Attachment "A".</p> <p>The checklist will assure that all residents admitted with indwelling catheters have related care plans.</p> <p>To ensure that performance is sustained, a monthly performance improvement indicator was developed:</p> <p># of residents with indwelling with care plans</p> <p># of residents with indwelling catheters</p> <p>Performance improvement is monitored monthly at the staff meetings &amp; quarterly at the performance improvement team meetings with the medical director.</p>	08/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy A. Morgan, RN, Director + Nursing Home Administrator TITLE: Director + Nursing Home Administrator (X6) DATE: 07/28/10

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 281	Continued From page 1 Therefore, no interventions were developed to guide staff related to resident #1's specific care needs regarding the indwelling urinary catheter.  Observation on July 6, 2010, at 12:45 p.m., revealed resident #1 had an indwelling catheter to bedside drainage.  Review of the physician's orders dated July 6, 2010, revealed an order to remove the indwelling catheter.  Interview on July 7, 2010, at 10:15 a.m., with the Nurse Preceptor revealed the Nurse Preceptor was responsible for the development of the interim care plans. Upon review of the interim care plan, the Nurse Preceptor stated the Nurse Preceptor must have just overlooked that resident #1 had an indwelling catheter. The Nurse Preceptor stated a care plan should have been developed upon admission to address resident #1's indwelling catheter and the care needs regarding the indwelling catheter.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure care was provided in accordance with the written plan of care for one (1) of ten (10) sampled residents (resident #3). Resident #3 was care planned to	F 282	In addition to the care plan section of the electronic medical record, specific care plan measures as identified by any discipline will be communicated to all disciplines by documenting the goal/measure on the "whiteboard" in a resident's room.  The whiteboard serves as an interdisciplinary & resident/family care centered communication tool.	08/10/10

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F 282	<p>Continued From page 2</p> <p>require 1630 milliliters of fluid intake in a 24-hour period and the physician and Registered Dietitian (RD) were to be notified when the resident's required fluid intake was not consumed. The facility failed to follow the written plan of care thus ensuring the resident received 1630 milliliters per 24-hour period and further failed to notify the physician and Registered Dietitian (RD) for five (5) consecutive days.</p> <p>The findings include:</p> <p>Review of resident #3's medical record revealed the resident's Minimum Data Set (MDS) assessment information was not available as resident #3 had only been admitted to the facility for four days prior to the survey.</p> <p>Review of resident #3's written plan of care revealed the resident was assessed by the Registered Dietitian (RD) on July 5, 2010, to require 1630 milliliters of fluid intake in a 24-hour period. The care plan directed staff if resident did not consume the recommended amount of fluid the facility was to notify the physician and the Registered Dietitian (RD).</p> <p>Review of resident #3's intake for July 2, 2010 through July 6, 2010, revealed resident #3 did not consume the RD recommended fluid for five consecutive days.</p> <p>Review of the nurse's notes dated July 2, 2010 through July 6, 2010, revealed the facility failed to notify the physician and the RD concerning resident #3 not consuming the recommended fluid intake as directed by the plan of care.</p> <p>Review of the RD initial assessment dated July 5,</p>	F 282	<p>Rounding by the Director will include checks for care-plan measures/goal communication on all residents to identify other residents with specific care plan needs &amp; to ensure performance improvement is sustained.</p>	

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F 282	<p>Continued From page 3</p> <p>2010, for resident #3 revealed the resident was assessed to require 1630 milliliters of fluid intake in a 24-hour period. However, no documentation was found that revealed the RD was notified of the resident failing to consume the assessed and care planned daily fluid requirement.</p> <p>Interview conducted on July 6, 2010, at 5:50 p.m., with State Registered Nurse Aide (SRNA) #2 revealed the dietary hostess was responsible for recording fluid intake after each meal. The SRNA was responsible for recording fluid intake consumed by the resident between meals. Further interview revealed the Registered Nurse (RN) was responsible to instruct the SRNA each day of any residents that had an amount of assessed fluid needs that should be consumed each day. The SRNA stated the RN reviewed the intake for each resident but the SRNA was unsure how often the RN reviewed the intake record.</p> <p>Interview on July 6, 2010, at 6:00 p.m., with RN #2, who was assigned to provide care for resident #3, revealed it was the responsibility of all staff to record intake for each resident. RN #2 stated the RN was unaware that the care plan stated that resident #3 was required to consume 1630 milliliters of fluid per day. Further interview revealed RN #2 was also unaware of the care plan which directed staff to notify the physician and RD if resident #3 did not consume the care planned fluid needs. RN #2 was unaware that resident #3 had not consumed the recommended fluid intake as directed by the plan of care.</p> <p>Interview with RN #3 (Nurse Preceptor) on July 7, 2010, at 10:15 a.m., revealed that residents were assessed upon admission to identify each</p>	F 282			

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F 282	Continued From page 4 resident's potential problems and the care plans were based on each resident's individual needs. RN #3 revealed resident #3 was assessed and care planned by RN #3 on July 2, 2010, and found to require a total fluid intake of 1630 milliliters per 24-hour period. Further interview revealed the RD performs a diet assessment on each resident and also calculates each resident's fluid needs using the same formula that RN #3 used. RN #3 stated the resident's primary RN was responsible to notify the physician when a resident had failed to consume the recommended fluid intake. RN #3 stated when a resident had not met their daily assessed fluid requirement the RN should consult all staff to ensure all intake had been recorded for the resident. If a resident did not meet the required fluid consumption, RN #3 stated a sign would be placed on the door that instructed staff to encourage more fluid. RN #3 stated the doctor would be notified if the resident's intake was not enough to meet the resident's daily requirements. RN #3 was unable to provide documentation that the facility had monitored fluid intake consumption for resident #3 for the five days.  Interview with the RD on July 7, 2010, at 2:10 p.m., revealed resident #3 was assessed on July 5, 2010, and was assessed to require 1630 milliliters of fluid intake in a 24-hour period. The interview further revealed the RD based the fluid requirement on the need of 25 milliliters per kilogram of body weight and stated that was the bare minimum required. Further interview revealed the RD had not been notified that resident #3 had not consumed the recommended daily fluid requirement.	F 282			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327	In addition to the care plan section of the electronic	08/10/10	

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F 327	<p>Continued From page 5</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to have an effective system in place to ensure that sufficient fluid intake to maintain proper hydration and health was provided to one (1) of ten (10) sampled residents. Resident #3 was assessed to be at risk for dehydration due to the diagnosis of anemia and the use of a diuretic. Resident #3's care plan dated July 2, 2010, revealed the resident required 1630 milliliters of fluid intake in a 24-hour period and the nursing staff was to notify the physician and the Registered Dietitian (RD) if the resident did not consume the recommended amount of fluids. The facility failed to identify that resident #3 did not consume the recommended fluid intake for five (5) consecutive days and the facility also failed to notify the physician or the RD.</p> <p>The findings include:</p> <p>Review of resident #3's medical record revealed on admission to the facility on July 2, 2010, the resident was assessed by the RD and the Preceptor Nurse to be at risk for dehydration due to diagnosis of anemia and the use of a diuretic.</p> <p>Review of resident #3's care plan dated July 2, 2010, revealed resident #3 required 1630 milliliters in a 24-hour period. Review of the care plan further stated that if resident #3 did not</p>	F 327	<p>medical record, the registered dietitian will ensure that the goal/measure is communicated via the "whiteboard" in the resident rooms. The whiteboard serves as an interdisciplinary &amp; resident/family communication tool.</p> <p>Rounding by the Director will include checks for hydration measures/goal communications on all residents to ensure that performance improvement is sustained.</p> <p>07/20/10 staff meeting addressed/communicated the importance of accurately documenting water pitcher intake on all residents.</p> <p>See Attachment "B".</p>		

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F 327	<p>Continued From page 6</p> <p>consume the assessed amount that the physician and the RD would be notified.</p> <p>Review of resident #3's intake since admission revealed the following total daily fluid consumption: July 2, 2010 - 750 milliliters of fluid, July 3, 2010 - 1280 milliliters of fluid, July 4, 2010 - 780 milliliters of fluid, July 5, 2010 - 1340 milliliters of fluid, and July 6, 2010 - 650 milliliters of fluid.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 on July 6, 2010, at 5:50 p.m., revealed the Registered Nurse (RN) informed the SRNAs which residents required intake and output recorded daily, and the amount of fluid each resident was to consume. SRNA #2 stated it was the responsibility of the dietary hostess to record meal consumption and fluid intake with each meal. SRNA #2 stated the SRNAs are responsible to record fluid intake consumed between meals. SRNA #2 further revealed the RNs reviewed intake and output records for each resident but SRNA #2 was not sure how often the RN conducted the review.</p> <p>Interview on July 7, 2010, at 10:15 a.m., with the Nurse Preceptor revealed the assessment of resident #3's fluid need for 1630 milliliters per day was based on assessing the resident as a whole and identifying any problems or potential problems the resident may have experienced. Interview further revealed that it was the responsibility of the RN that was assigned to the resident to assess daily intake and output and to notify the appropriate person if there was a problem. The Nurse Preceptor stated that in the event a resident was not meeting the assessed fluid requirement, the RN should consult staff to</p>	F 327		

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F 327	<p>Continued From page 7</p> <p>be sure all intakes had been recorded. The Nurse Preceptor stated a sign would be placed on the door that instructed staff to encourage more fluids for the resident. The Nurse Preceptor stated the physician would be notified if the intake was not enough to meet the resident's daily requirements. The Nurse Preceptor was unable to provide documentation that the facility had identified that resident #3 had failed to consume the recommended fluid intake for five consecutive days.</p> <p>Interview with RN #2, resident #3's primary RN, conducted on July 6, 2010, at 6:00 p.m., revealed that all staff was responsible for recording the residents' intake and output. RN #2 stated the RN was unaware of the dietitian's recommended daily fluid needs for resident #3. Due to staff not being aware that resident #3 had not consumed the assessed daily fluid needs, no alternative treatment/approaches were developed in an attempt to increase resident #3's daily fluid intake.</p> <p>Interview with the Registered Dietitian (RD) on July 7, 2010, at 2:10 p.m., revealed the RD assessed all residents upon admission. The RD stated the bare minimum for a resident is 25 milliliters per kilogram of body weight, and after review of resident #3's medical history the recommended fluid consumption for resident #3 was 1630 milliliters of fluid per 24-hour period. The RD stated residents' intake should be assessed daily. Further interview with the RD revealed the RD was unaware resident #3 had not met the recommended needs to maintain the resident's hydration.</p> <p>Observations made on July 6, 2010 and July 7, 2010, of resident #3 revealed a pitcher of water at</p>	F 327			

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F 327	Continued From page 8 the resident's bedside. Further observation revealed resident #3 drinking fluid with each meal and while taking medication. Observation further revealed resident #3 to have adequate skin turgor, mucous membranes were moist, and urinary output was clear and yellow, with no foul odor. No signs of dehydration were noted.  Review of the facility's policy dated April 2008 revealed residents that required the use of diuretics would have all intake and/or output monitored. The policy entitled Plan for Provision of Care, Treatment and Services failed to direct staff of measures to take if a resident did not consume the recommended fluid needs.	F 327			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  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.	F 431	Metal spacers will be applied to medication cart drawers to ensure locking of carts.  Additionally, the purchase of (2) replacement medication carts has been authorized for this fiscal year.  Authorization Date: 07/09/10  These (2) carts are the only carts in the organization. All other service lines have electronic medication dispensing cabinets. (No others are affected). Locking of medication carts to a secure lock will be monitored using the Medication Management Team's Tool for Performance Improvement & reported @ the	08/20/10	

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F 431	<p>Continued From page 9</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store drugs and biologicals in accordance with State and Federal regulations. Observations during the survey on July 6, 2010 and July 7, 2010, revealed the medication cart would lock but the individual resident drawers could be opened, permitting unauthorized access to resident medications.</p> <p>The findings include:</p> <p>Observations on July 6, 2010, at 1:05 p.m. and 5:25 p.m., revealed the medication cart, which was stored in the hallway throughout the survey, was locked; however, the individual resident drawers could be opened. Further observation on July 7, 2010, at 11:00 a.m., revealed the medication cart was not locked allowing visitors, staff, or other passersby access to the individual drawers that contained resident medications.</p> <p>During the process of checking the medication cart on July 7, 2010, at 11:00 a.m., a resident and two visitors were observed to walk past the</p>	F 431	monthly medication management meetings.	

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F 431	Continued From page 10 unsecured medication cart.  Interview with RN #5 on July 7, 2010, at 11:05 a.m., revealed the medication cart had been malfunctioning and was not locking properly. RN #5 stated the RN had reported to the pharmacy and supervisor that the medication cart would lock but the individual resident drawers could be still be opened.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	To prevent the development & transmission of disease & infection, the following has taken place: 1) Specific counselling of RN #1 by the RN's Director. 2) Handwashing Performance Improvement Measure & Tool. See Attachment "C", that ensures compliance for all residents by other health care workers. 3) The Performance Improvement results are reviewed & reported @ the Infection Control Committee with Accountability for compliance. See Attachment "D".	08/10/10

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

PRINTED: 07/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/07/2010
NAME OF PROVIDER OR SUPPLIER  EPHRAIM MCDOWELL REGIONAL MEDICAL CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 217 SOUTH THIRD STREET DANVILLE, KY 40422		
(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 441	<p>Continued From page 11</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, it was determined the facility failed to maintain an effective infection control program. Observation of medication administration on July 6, 2010, revealed staff failed to wash/sanitize hands between resident contact. The staff also failed to don gloves during administration of subcutaneous medications administered to resident #9 and resident #10.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Observation of the med pass on July 6, 2010, at 4:17 p.m., revealed Registered Nurse (RN) #1 administered NovoLog 2 units subcutaneously to resident #10 in the left upper arm. RN #1 failed to wash/sanitize hands prior to and after administering injection to the resident, and failed to don gloves prior to administering injection.</li> <li>2. Further observation of the medication pass on July 6, 2010, at 5:25 p.m., revealed RN #1 prepared two oral medications, one subcutaneous medication, and one intravenous medication for resident #9. RN #1 administered the oral medications to resident #9, and then exposed resident #9's abdomen and administered Lovenox</li> </ol>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/07/2010
NAME OF PROVIDER OR SUPPLIER  EPHRAIM MCDOWELL REGIONAL MEDICAL CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 217 SOUTH THIRD STREET DANVILLE, KY 40422		
(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 441	Continued From page 12 40 milligrams subcutaneously in the resident's left lower abdomen. RN #1 then administered Zosyn 3.375 milligrams intravenously. Observation during the procedure revealed resident #9's abdomen was grossly distended, the resident's skin was extremely jaundiced, and a dressing was noted on the resident's left foot. RN #1 failed to don gloves to administer the subcutaneous injection and also failed to wash/sanitize hands after direct contact with the resident.  A review of the hand hygiene policy dated February 1, 2008, revealed all associates should perform hand hygiene before having direct contact with a patient and immediately after having contact with a patient. The policy also directed staff to don gloves/personal protective equipment if appropriate.  An interview with RN #1 was conducted on July 6, 2010, at 6:00 p.m. RN #1 stated, "I should have washed my hands prior to and after I gave the injection. I am just not myself today. I had a bad day yesterday, and had to have my horse put down. I was just not thinking."  An interview conducted on July 7, 2010, at 10:30 a.m., with the Nurse Preceptor revealed all nurses should wear gloves with any subcutaneous injection, for protection of the nurse and for the residents.	F 441			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	Water spots: Paint will be applied to the cabinet side-wall & plexiglass guards will be installed to prevent further water spots. (#418, 422, 423, & 427).  Doorway Entries: (418, 426, &	08/20/10	

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

PRINTED: 07/21/2010  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/07/2010
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NAME OF PROVIDER OR SUPPLIER  EPHRAIM MCDOWELL REGIONAL MEDICAL CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 217 SOUTH THIRD STREET DANVILLE, KY 40422
---	---

(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
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F 465	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>The findings include:</p> <p>1. Observation of the facility during the environmental tour on July 6-7, 2010, revealed the following items were in need of maintenance/repair:</p> <ul style="list-style-type: none"> <li>-Water spots were observed on the wall beside the sink in resident rooms 418, 422, 423 and 427;</li> <li>-The entry door to resident rooms 418, 426, and 429 had chipped/splintered wood;</li> <li>-In resident room 427 the porcelain in the bathtub and the drywall on the ceiling was peeling/flaking;</li> <li>-The wallpaper on the corner of resident rooms 427 and 417 was chipped; and</li> <li>-The drywall in resident room 424 had elongated horizontal scratches.</li> </ul> <p>Interview on July 7, 2010, at 1:45 p.m., with the Director of Engineering (DE) revealed daily rounds were conducted to detect any items in need of repair. The DE stated staff can report any item in need of repair by activating the medtec system and send a work order or staff can call the Engineering Department. The DE stated the items identified had just been missed on the daily rounds.</p>	F 465	<p>429) shall be filled with plastic wood, sanded, smoothed &amp; urethane finish applied to seal surfaces.</p> <p>(427) Bathtub porcelain will be reglazed to restore finish. Ceiling drywall shall be repaired to a smooth finish.</p> <p>(427 &amp; 417) will install cover guards to further prevent chipping.</p> <p>(427)Drywall will be repaired &amp; painted.</p> <p>All additional rooms in SNF will be reviewed for similar findings by the Director/Nursing Home Administrator.</p> <p>Measure for ensuring daily engineering rounds cover the environmental issues found includes adding items to the list.</p> <p>Meeting these standards will be monitored by reports &amp; cross-ro;unding by Director/Administrator.</p>	
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## TCU ADMISSION CHECK LIST

- CHECK INSURANCE/PAY SOURCE-** HAVE IT CLEARED WITH SOCIAL WORKER. LETTER MUST BE GIVEN FOR SOME INSURANCES
- PRE ADMIT PATIENT-** EMAIL ROBIN SAYLOR OR SYLVIA LYNCH TO HAVE INFO PUT INTO COMPUTER- NEED NAME, DOB, DX, AND DR.
- D/C SUMMARY-** FROM ACUTE CARE
- HISTORY AND PHYSICAL-** ADMITTED TO ACUTE CARE
- CERTIFICATION- MEDICARE-**PHYSICIAN TO SIGN BEFORE ADMISSION TO TCU
- ORDERS-** MUST DC SUMMARY OR PHYSICIAN TO SIGN MAR AND WRITE ORDERS.( PINGLETON DOES HER OWN ORDERS). USE CPOE
- STANDARD OF CARE-LTC**
- CARE PLAN-** MUST HAVE 2 PROBLEMS IN FIRST 24 HOURS
- IF INDWELLING FOLEY CATH PRESENT, INITIATE CARE PLAN**
- MEDICATION RECONCILIATION RECORD WITH DIAGNOSIS FOR EACH MEDICATION** – DO NOT SEND TO PHARMACY UNTIL THE DIAGNOSES ARE ON THE MAR
- FALLS EDUCATION SHEET-**IN NOTES SECTION
- PAIN EDUCATION SHEET-**IN NOTES SECTION
- TCU WELCOME LETTER-**IN NOTES SECTION
- CHANGE THE FREQUENCY FOR THE LTC WEEKLY/MONTHLY SUMMARY** - 7DAYS FROM ADM.
- FOR ORTHO /CANCER/PAIN DIAGNOSIS** -CHANGE THE PAIN ASSESS TO Q2HR IF ORTHO PATIENT AND QS FOR OTHERS
- IF PATIENT IS SURGICAL PATIENT OR HEART FAILURE PATIENT-** ADD EDEMA ASSESSMENT TO INTERVENTIONS
- IF PATIENT IS GOING IN A PRIVATE ROOM DOCUMENT ON THE PROCESS ACCT .REASON FOR PRIVATE ROOM-**  
**PATIENT REQUEST-PATIENT/FAMILY RESPONSIBLE FOR THE DIFFERENCE IN THE ROOM CHARGE**  
**MEDICALLY NECESSARY** –NO CHARGE FOR PRIVATE ROOM COST
- DIABETIC PATIENTS WITH SLIDING SCALE DOSING-**ADD BLOOD GLUCOSE TO INTERVENTIONS AND PRINT PROTOCOL FROM “CPOE”
- CHECK THE VACCINATION HISTORY AND ADD TO ORDERS**
- PUT PULL AWAY ALARM ON PATIENTS AT RISK** –AND ADD INTERVENTION
- CHECK ORDERS FROM ACUTE CARE FOR NEW ORDERS**
- IF TUBE FEEDING PATIENT** – COMPLETE THE PROTOCOL SHEET
- PICC LINE OR CENTRAL LINE-** PROTOCOL ADDED FROM “CPOE”
- WOCN ORDERS AND CONSULTATION COMPLETE**
- DVT PROPHYLAXIS**

		<b>with prompt to: Teach New Meds &amp; focus on ABx. &amp; PAIN MEDS.</b>
<b>III. Relationships</b> A. Pt. Satisfaction	A. Pt. Satisfaction score in June did not meet goal: 92.5% Goal is 93%. An Action Plan is needed: <b>Rounding shift to shift &amp; hourly rounding!!!</b> B. HCAHPS scores will be shared.	<i>A.1. Maintain Action Plan of: "ROUNDING Hourly, shift to shift &amp; (3) P's: Position, Potty &amp; Pain. 2. Discharge letters will be issued within 48 hours of Discharge/CMS rule &amp; also a patient/family/physician satisfier.</i>
<b>IV. Safety</b>		
Open Response request for Administration of Medications	A. Campbell, RN, presented a request to have an Open Response for Medication Admin. Reasons/ Comments. She noted that there are several reasons that are not listed, i.e. patient's family request to hold medications for now or not to give. The only available one is "Pt. Refuses".	To Medication Management, Meditech Messengers. Emailed 06/20/10/JASM—J. Morgan will check about the E MAIL & Agenda.
<b>A. OPENed Vials &amp; Meds.</b>	A. New Opened Vial check/frequency of q. 12 hours.	<i>A. Check vials q. 12 hours.</i>
<b>New Business</b>		
<b>I. Operational Effectiveness</b>		
A. CMS/OIG Annual Unannounced Survey 07/06 & 07/07/10.	A. J. Morgan Congratulated the Associates on an Excellent OIG/CMS Survey. There were no patient quality issues/deficiencies. The following were discussed: Med. Carts not locked, Care plan not updated to reflect F.Cath left in on Acute Care. Fluid intake not accurate/	<b>A. Await CMS/OIG Survey results in writing. &amp;: Med. Carts will have spacers placed to enhance locking until new carts can be ordered. Update Care Plans to reflect "real time". Document I &amp; O—especially water pitcher intake.</b>
<b>B. Equipment Wish List</b>	<b>B. J. Morgan requested input for equipment wish list on TCU: Discussed --already approved 1 or 2 Vital Signs Carts &amp; 2 or 3 med. carts. Bladder scanner for 3T &amp; 6T in addition to 3T's adult scanner. Future blanket warmer—consider temp. cks. Every 12 hours &amp; in a locked, secure area.</b>	J. Morgan will place items on list for Capital equipment. Licensed nurses will be involved in selective criteria for med. Carts * i.e. maneuverability, size, space. J. Morgan will check with Bio Med. Re. stand up scale functionality/timing.

Attachment "B"

## Beetles Hand Hygiene & Contact Precautions Monitoring Tool

Week of: \_\_\_\_\_ Monitored by: \_\_\_\_\_

**Healthcare Worker (HCW)**

- |                      |   |                          |                        |   |                            |
|----------------------|---|--------------------------|------------------------|---|----------------------------|
| A – Agency           | CV – Cardiovascular (Echo, EKG, Cath Lab) | ICU – ICU Nursing        | PC – Pastoral Care     | SS – Surgical Services (OR, Holding, Recovery, Pain Clinic, CS) | T – Transporters           |
| 3T – 3T Nursing      | D – Dietary/Hostess                       | Lab – Laboratory         | PH – Pharmacy          | ST – Student  | TCU – Nursing              |
| 4T – 4T Nursing      | DI – Diagnostic Imaging                   | P – Physician            | PR – Patient Relations | Tel – Telemetry   | V – Volunteer              |
| 5T – 5T Nursing      | ED – ED Nursing                           | PA – Physician Assistant | RE – Rehab (OT/PT/ST)  |   | WHC – Wound Healing Center |
| BHS – BHS Nursing    | ES – Environmental Services               | NP – Nurse Practitioner  | RT – Respiratory       |   | WH – WH/Nsy/L&D            |
| CM – Case Manager/SW |   | OSC – Ortho Spine Center |                        |   |                            |

Mark in each block the letter for the HCW with the opportunity requiring Hand Hygiene/Contact Precautions. In the adjacent block indicate if hand hygiene/contact precautions was performed by marking (Y) Yes or if not performed by marking (N) No. If marked No, please include the HCW's name and make comment as to circumstances surrounding the noncompliance. **Document Name of Physician for YES and NO's. (Try to observe 3 to 5 physicians).** Complete the Accountability Form for non-compliant HCWs and physicians and forward the form to the HCW's department director or to Debbie Clark for physicians.

**HAND HYGIENE:**

	Date	Shift	HCW	Y/N	Dept Dir Notified by C.E.	Person's Name (No's only, unless observe physician)	Comments
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

**CONTACT PRECAUTIONS:**

	Date	Shift	HCW	Y/N	Dept Dir Notified by C.E.	Person's Name (No's only, unless observe physician)	Comments
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.	Family/Visitor: <input type="checkbox"/> Yes <input type="checkbox"/> No						
20.	Family/Visitor: <input type="checkbox"/> Yes <input type="checkbox"/> No						

Artificial Finger Nails Seen Observed:  Yes  No If yes, please provide name(s): \_\_\_\_\_

Revised 1/5/2010

*Attachment "C"*



## Hand Hygiene/Contact Precautions Review

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\_\_\_\_\_ did NOT comply with the following:  
(Associate's Name)

Hand Hygiene

Contact Precautions

Date observed: \_\_\_\_\_

Date observed: \_\_\_\_\_

**Department:**

**Additional Comments:**

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**Response from Director:**

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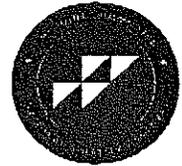
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**Forward to:**

Infection Control Coordinator

Vice President

Other: \_\_\_\_\_



Ephraim McDowell Regional Medical Center Nursing Facility

Provider# 185405

License# 100710

08/09/10 Addendum to the OIG/CMS Survey:

This addendum is in response to the questions regarding the 07/28/10 Plan of Correction.

F282 After each 24 hour total intake and output is totaled, the amounts if insufficient to the plan of care goal, will be communicated to the next shift and the physician will be notified by the licensed nurse. The Registered Dietician will be responsible for communicating specific goals to the licensed nurse as well as assuring that the goals are recorded on the whiteboard so that patient/family centered care can be utilized as well as other disciplines involved in the care of the patient to meet the goals.

Inservice of the nursing staff was done on 07/20/10 @ the monthly nursing meeting. All Associates received copies of the minutes & attached is a list of those attending, their titles & a list of those who acknowledged the posted minutes. Attachments E. & F.

The content of the inservice: Attachment G.

F441 Handwashing monitoring for each service line is on a schedule of quarterly & ensures that hand hygiene and infection control measures are sustained throughout the organization. There is no stop date for handwashing monitoring for the organization. It is continuous. Attached is the monitoring schedule with the Transitional Care unit asterisked and circled. Attachment H. The next period of monitoring begins August 30. The Organization has zero tolerance of non-compliance regarding infection control. The attachment I. is the accountability form that demonstrates that the Director and Associate or Physician involved must have a response or plan of corrections to ensure that this does not happen again. The accountability is then forwarded to the Infection Control Coordinator, Vice President and if applicable, the Credentialing Committee and Department of Medicine for Physicians and retained in that individual's file.

Judy A. Morgan, RN, Director/ Nursing Home Administrator

08/09/10

### Training & Development Program Roster

Date: 7/20/10 Time: 7:30 A

Topic: Monthly Dept. Meeting

Speaker: Judy Morgan

Target Audience: All employees

#	Name of Participant	Department
1	J. Johnson RN	
2	J. Morgan RN	
3	Mrs. Moore Per	
4	Amie Campbell RN	
5	Amber Dennis Per	
6	J. Anderson LPA	TCU
7	Nancy Byrd RN	
8	Wendy Harty RN	
9	B. J. J. J.	TCU
10	C. Campbell AD	TCU
11	J. Dooty WIC Per	TCU
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
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25		
26		
27		
28		
29		
30		

*Please Sign + Date after reading Minutes T.C.U. July*

*Jan 7-20 PCT a complete for 7/20/10*

*LBA Curran PCT 7/20*

*P. Reedy PCT 7-21-10*  
*X. Hester PCT 7-21-10*

*Tamy Hana PCT 7-22-10*

**TCU Monthly Meeting**  
**EPHRAIM MCDOWELL REGIONAL MEDICAL CENTER**  
**07/20/10 @ 0730 TCU Activity Rm.**

**ATTENDANCE:** See attached

TOPIC	CONCLUSIONS/RECOMMENDATIONS	ACTION/FOLLOW-UP
<b>Old Business</b> <b>I. Operational Effectiveness</b>	<i>Boyd</i>	
A. MEDITECH	A. Meditech Update 1. PCM = Physician Care Module of Order Entry, Progress notes, etc. plan: AUGUST 17th. See posted JULY INSERVICES!!!!!!!	<b>***ATTEND PCM July Inservices</b> <b>**2 remaining: July 27<sup>th</sup> 0745-845 &amp; July 29<sup>th</sup> 3-4PM****.</b> <b>PCM Superusers:</b> <b>A shift: Anna Davis &amp; Pat Walls</b> <b>B Shift: N. Byrd &amp; Cathy Adams.</b>
B. 4 Pillars	B. June Scorecard reviewed finances related to decreased patient days, & PI.	B. SCORECARD for June posted.
C. TCU's move.	C. J. Morgan shared w TCU Associates about plans for TCU:	<b>C. Application submitted OIG/CMS by our Architect.</b>
D. RAC Auditor Report/D/C Disposition	D/ Jennifer Moore presented the RAC audit, explaining that 80 Medicare charts were reviewed & EMRMC is in good standing so far. **RAC is the Recover \$ from institutions for not documenting what you did.	D. D/C Disposition: be sure = correct in the Discharge Intervention. Document <i>Date, Time &amp; Who</i> you talked with when transferring a pt.

<b>II. Clinical Effectiveness</b>		
A. Blood Transfusion F UP	A. 1/1—100% Transfusion documentation.	A. See Status Board PI
B. W/Ch. Comm.	B. No Report.	B.
C. Medications Effects --- New Meds.	C. Medication Effects --- New Meds. TEACH!!!! New prompt in MEDITECH. Idea, T You to M. L. Metz for this Action>>>>>>>>	<b>C.**Unit Sec. prints off New Med. &amp; highlights, hands to RN or LPN</b>

*Attachment F.*

Intake and Output Education 07/20/10

Transitional Care Unit

Janet Short Johnson, RN, presented the Intake and Output Education to the Transitional Care Unit Associates.

Key points of the education included:

- 1) Review of the goal of the fluid intake. Goal is posted on the Whiteboard/Communication Board in the Patient's room by the dietician.
- 2) Include/communicate to the patient and family the fluid intake goal.
- 3) Utilize paper intake and output conversion tool for checklist of intake for patient/family, every 24 hours. (i.e. sherbert, 3 ounces= 88 ml.)
- 4) Document real time into the electronic medical record's Intervention: Intake & Output
- 5) RN's & LPN's, be sure to include liquids given with oral medications as intake.
- 6) C. N.A's, be sure that you are counting water pitcher intake as well as meals and snacks.
- 7) Activity Coordinator, be sure that you are counting fluid intake consumed during activities.
- 8) Licensed nurses, communicate shift to shift any variation in fluid intake goal so that the physician can be notified in a timely manner of the variation.

## Beetles Hand Hygiene/Contact Precautions Monitoring Schedule 2010

Beetle/Area	1st Month of the Quarter			
	January	April	July	October
Ann Adams, Lab	Jan 4-10	Apr 5-11	July 5-11	Oct 4-10
Emma Bates, Cath Lab	Jan 11-17	Apr 12-18	July 12-18	Oct 11-17
Stephanie Kilby, NSY Georgeanna Arnold, WH	Jan 18-24	Apr 19-25	July 19-25	Oct 18-24
Pam Young, DI	Jan 25-31	Apr 26-30	July 26-31	Oct 25-31
	2nd Month of the Quarter			
	February	May	August	November
Georgeanna Grant, ICU Mark Fluty, Dietary	Feb 1-7	May 3-9	Aug 2-8	Nov 1-7
Joyce Young, OR Mike Tracy, E.S.	Feb 8-14	May 10-16	Aug 9-15	Nov 8-14
Kristin Steele, 3T	Feb 15-21	May 17-23	Aug 16-22	Nov 15-21
Kelly Coulter, OSC Sharon Dailey, SW Telemetry	Feb 22-28	May 24-30	Aug 23-29	Nov 22-28
	3rd Month of the Quarter			
	March	June	September	December
ICU (Carole Campbell, Anna Davis, Tiva Foster, Lynn Holsclaw, Janet Short Johnson)	Mar 1-7	May 31 - June 6	Aug 30 - Sept 5	Nov 29 - Dec 5
Carla Reynolds, Recovery & OPAD	Mar 8-14	June 7-13	Sept 6-12	Dec 6-12
Christy Miles, BHS	Mar 15-21	June 14-20	Sept 13-19	Dec 13-19
Debbie Goodwin, ED	Mar 22-28	June 21-27	Sept 20-26	Dec 20-26

Beetles	Location to monitor	Monitor the 1 <sup>st</sup> month of each quarter (January, April, July, October)
Nathan Moore	MedSource	
Julie Hilbert	Diagnostic Center (Southtown)	
Brittany Moore	Outpatient Rehab	
Angie Salyers	Wound Center	

Attachment H.



## Hand Hygiene/Contact Precautions Review

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\_\_\_\_\_ did NOT comply with the following:  
(Associate's Name)

Hand Hygiene

Contact Precautions

Date observed: \_\_\_\_\_

Date observed: \_\_\_\_\_

Department:

Additional Comments:

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Response from Director:

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Forward to:

Infection Control Coordinator

Vice President

Other: \_\_\_\_\_

Notice to Director: Hand Hygiene/Contact Precautions

Received Time Aug. 10. 2010 10:15AM No. 1974

Attachment **I.**

## TCU ADMISSION CHECK LIST

- CHECK INSURANCE/PAY SOURCE-** HAVE IT CLEARED WITH SOCIAL WORKER. LETTER MUST BE GIVEN FOR SOME INSURANCES
- PRE ADMIT PATIENT-** EMAIL ROBIN SAYLOR OR SYLVIA LYNCH TO HAVE INFO PUT INTO COMPUTER- NEED NAME, DOB, DX, AND DR.
- D/C SUMMARY-** FROM ACUTE CARE
- HISTORY AND PHYSICAL-** ADMITTED TO ACUTE CARE
- CERTIFICATION- MEDICARE-** PHYSICIAN TO SIGN BEFORE ADMISSION TO TCU
- ORDERS-** MUST DC SUMMARY OR PHYSICIAN TO SIGN MAR AND WRITE ORDERS. (PINGLETON DOES HER OWN ORDERS). USE CPOE
- STANDARD OF CARE-LTC**
- CARE PLAN-** MUST HAVE 2 PROBLEMS IN FIRST 24 HOURS
- IF INDWELLING FOLEY CATH PRESENT, INITIATE CARE PLAN**
- MEDICATION RECONCILIATION RECORD WITH DIAGNOSIS FOR EACH MEDICATION** – DO NOT SEND TO PHARMACY UNTIL THE DIAGNOSES ARE ON THE MAR
- FALLS EDUCATION SHEET-** IN NOTES SECTION
- PAIN EDUCATION SHEET-** IN NOTES SECTION
- TCU WELCOME LETTER-** IN NOTES SECTION
- CHANGE THE FREQUENCY FOR THE LTC WEEKLY/MONTHLY SUMMARY** - 7 DAYS FROM ADM.
- FOR ORTHO /CANCER/PAIN DIAGNOSIS** -CHANGE THE PAIN ASSESS TO Q2HR IF ORTHO PATIENT AND QS FOR OTHERS
- IF PATIENT IS SURGICAL PATIENT OR HEART FAILURE PATIENT-** ADD EDEMA ASSESSMENT TO INTERVENTIONS
- IF PATIENT IS GOING IN A PRIVATE ROOM DOCUMENT ON THE PROCESS ACCT .REASON FOR PRIVATE ROOM-**  
**PATIENT REQUEST-PATIENT/FAMILY RESPONSIBLE FOR THE DIFFERENCE IN THE ROOM CHARGE**  
**MEDICALLY NECESSARY** –NO CHARGE FOR PRIVATE ROOM COST
- DIABETIC PATIENTS WITH SLIDING SCALE DOSING-**ADD BLOOD GLUCOSE TO INTERVENTIONS AND PRINT PROTOCOL FROM “CPOE”
- CHECK THE VACCINATION HISTORY AND ADD TO ORDERS**
- PUT PULL AWAY ALARM ON PATIENTS AT RISK** –AND ADD INTERVENTION
- CHECK ORDERS FROM ACUTE CARE FOR NEW ORDERS**
- IF TUBE FEEDING PATIENT** – COMPLETE THE PROTOCOL SHEET
- PICC LINE OR CENTRAL LINE-** PROTOCOL ADDED FROM “CPOE”
- WOCN ORDERS AND CONSULTATION COMPLETE**
- DVT PROPHYLAXIS**

		<b>with prompt to: Teach New Meds &amp; focus on ABx. &amp; PAIN MEDS.</b>
<b>III. Relationships</b> A. Pt. Satisfaction	A. Pt. Satisfaction score in June did not meet goal: 92.5% Goal is 93%. An Action Plan is needed: <b>Rounding shift to shift &amp; hourly rounding!!!</b> B. HCAHPS scores will be shared.	<i>A.1. Maintain Action Plan of: "ROUNDING Hourly, shift to shift &amp; (3) P's: Position, Potty &amp; Pain. 2. Discharge letters will be issued within <u>48 hours of Discharge/CMS rule &amp; also a patient/family/physician satisfier.</u></i>
<b>IV. Safety</b>		
Open Response request for Administration of Medications	A. Campbell, RN, presented a request to have an Open Response for Medication Admin. Reasons/ Comments. She noted that there are several reasons that are not listed, i.e. patient's family request to hold medications for now or not to give. The only available one is "Pt. Refuses".	To Medication Management, Meditech Messengers. Emailed 06/20/10/JASM—J. Morgan will check about the E MAIL & Agenda.
<b>A. OPENed Vials &amp; Meds.</b>	A. New Opened Vial check/frequency of q. 12 hours.	<i>A. Check vials q. 12 hours.</i>
<b>New Business</b>		
<b>I. Operational Effectiveness</b>		
A. CMS/OIG Annual Unannounced Survey 07/06 & 07/07/10.	A. J. Morgan Congratulated the Associates on an Excellent OIG/CMS Survey. There were no patient quality issues/deficiencies. The following were discussed: Med. Carts not locked, Care plan not updated to reflect F.Cath left in on Acute Care. Fluid intake not accurate/	<b>A. Await CMS/OIG Survey results in writing. &amp;: Med. Carts will have spacers placed to enhance locking until new carts can be ordered. Update Care Plans to reflect "real time". Document I &amp; O—especially water pitcher intake.</b>
<b>B. Equipment Wish List</b>	<b>B. J. Morgan requested input for equipment wish list on TCU: Discussed --already approved 1 or 2 Vital Signs Carts &amp; 2 or 3 med. carts. Bladder scanner for 3T &amp; 6T in addition to 3T's adult scanner. Future blanket warmer—consider temp. cks. Every 12 hours &amp; in a locked, secure area.</b>	J. Morgan will place items on list for Capital equipment. Licensed nurses will be involved in selective criteria for med. Carts * i.e. maneuverability, size, space. J. Morgan will check with Bio Med. Re. stand up scale functionality/timing.

Attachment "B"

## Beetles Hand Hygiene & Con. Precautions Monitoring Tool

Week of: \_\_\_\_\_ Monitored by: \_\_\_\_\_

### Healthcare Worker (HCW)

- |  |  |   |
|--|--|---|
| <b>A</b> – Agency<br><b>3T</b> – 3T Nursing<br><b>4T</b> – 4T Nursing<br><b>5T</b> – 5T Nursing<br><b>BHS</b> – BHS Nursing<br><b>CM</b> – Case Manager/SW | <b>CV</b> – Cardiovascular (Echo, EKG, Cath Lab)<br><b>D</b> – Dietary/Hostess<br><b>DI</b> – Diagnostic Imaging<br><b>ED</b> – ED Nursing<br><b>ES</b> – Environmental Services | <b>ICU</b> – ICU Nursing<br><b>Lab</b> – Laboratory<br><b>P</b> – Physician<br><b>PA</b> – Physician Assistant<br><b>NP</b> – Nurse Practitioner<br><b>OSC</b> – Ortho Spine Center |
| <b>PC</b> – Pastoral Care<br><b>PH</b> – Pharmacy<br><b>PR</b> – Patient Relations<br><b>RE</b> – Rehab (OT/PT/ST)<br><b>RT</b> – Respiratory              | <b>SS</b> – Surgical Services (OR, Holding, Recovery, Pain Clinic, CS)<br><b>ST</b> – Student<br><b>Tel</b> – Telemetry  | <b>T</b> – Transporters<br><b>TCU</b> – Nursing<br><b>V</b> – Volunteer<br><b>WHC</b> – Wound Healing Center<br><b>WH</b> – WH/Nsy/L&D  |

Mark in each block the letter for the HCW with the opportunity requiring Hand Hygiene/Contact Precautions. In the adjacent block indicate if hand hygiene/contact precautions was performed by marking (Y) Yes or if not performed by marking (N) No. If marked No, please include the HCW's name and make comment as to circumstances surrounding the noncompliance. **Document Name of Physician for YES and NO's. (Try to observe 3 to 5 physicians).** Complete the Accountability Form for non-compliant HCWs and physicians and forward the form to the HCW's department director or to Debbie Clark for physicians.

### HAND HYGIENE:

	Date	Shift	HCW	Y/N	Dept Dir Notified by C.E.	Person's Name (No's only, unless observe physician)	Comments
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

### CONTACT PRECAUTIONS:

	Date	Shift	HCW	Y/N	Dept Dir Notified by C.E.	Person's Name (No's only, unless observe physician)	Comments
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.	Family/Visitor: <input type="checkbox"/> Yes <input type="checkbox"/> No						
20.	Family/Visitor: <input type="checkbox"/> Yes <input type="checkbox"/> No						

Artificial Finger Nails Seen Observed:  Yes  No If yes, please provide name(s). \_\_\_\_\_

Revised 1/5/2010

*Attachment "C"*

## Hand Hygiene/Contact Precautions Review

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\_\_\_\_\_ did NOT comply with the following:  
(Associate's Name)

Hand Hygiene

Contact Precautions

Date observed: \_\_\_\_\_

Date observed: \_\_\_\_\_

**Department:**

**Additional Comments:**

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**Response from Director:**

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**Forward to:**

Infection Control Coordinator

Vice President

Other: \_\_\_\_\_

Notice to Director: Hand Hygiene/Contact Precautions

Attachment "D"