

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

PRINTED: 11/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/28/2011
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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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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	Martin's Rest Home D.B.A. Grand Haven Nursing Home does not believe nor does the facility admit that any deficiencies exist. Grand Haven Nursing Home reserves all rights to contest the survey findings through informal dispute resolution, formal appeals proceedings or any other applicable administrative or legal proceeding. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Grand Haven Nursing Home reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered a waiver of any potentially applicable peer review, quality assurance or self-critical examination privilege, which Grand Haven Nursing Home does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Grand Haven Nursing Home offers its response, plan of correction and credible allegation of compliance as part of its ongoing effort to provide quality care to its residents. Grand Haven Nursing Home strives to provide the highest quality care while assuring the rights and safety of its residents.	
F 157 SS=E	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 this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Thomas E. N...</i> WHA	TITLE 11-18-11	(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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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031	
(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 157	<p>Continued From page 1 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 it was determined the facility failed to notify the physicians when physician ordered pulse oxymetry readings on room air were not obtained for five (5) of twelve (12) sampled residents (Residents #1, #2, #5, #7, and #9).</p> <p>The findings include:</p> <p>Review of the facility's policy "Notification of Physician" revised June 1996 revealed no documented evidence the facility established guidelines for physician notification when residents' pulse oxymetry readings were not obtained.</p> <p>1. Record review revealed the facility admitted Resident #1 with diagnoses which included Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Review of the Physician's Orders, dated October 2011, for Resident #1 revealed an order for Oxygen at two (2) liters/minute (L/m) per Nasal Cannula (NC). Additionally there was an order to check oxygen saturation on room air each shift.</p> <p>Review of the Treatment Administration Record (TAR) for September and October 2011 revealed the oxygen saturation checks were not completed as ordered. Per the TAR the nurses Initialed and circled the oxygen saturation check, indicating the</p>	F-157	<p>1. The charge nurse notified Physicians and resident/legal representative as follows that pulse oxymetry readings on room air were not obtained as ordered by the physicians: Resident #1 legal representative notification 10/22/11, MD notification 10/28/11; Resident #2 MD and legal representative notification on 11-1-11; Resident #5 MD and legal representative notification on 11-1-11; Resident #7 & #9 legal representative and MD notification on 10-28-11.</p> <p>2. The DON and ADON assessed all other residents that have orders for oxygen saturation levels on 10/28/11 on 2nd shift to assure that physician ordered oxymetry was being obtained; physicians and legal representatives were notified as appropriate on 10/28/11. As of 10/28/11 on 2nd shift all residents with physician ordered oxymetry was being appropriately obtained. The DON did on-the-spot verbal re-education with nurses on staff at that time regarding following MD orders. No residents were negatively affected by not having oxymetry completed.</p> <p>3. The facility's policy "Notification of Physicians" was revised on 11-7-11 by the DON with the approval of the Medical Director and QA committee on 11-8-11 to include specific guidelines for physician notification if pulse oxymetry is not being obtained as ordered by the physician, further revision includes specific</p>	

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F 157	<p>Continued From page 2</p> <p>checks were not completed during the months of September and October for Resident #1.</p> <p>Review of the Nurses Notes revealed no document evidence the Physician was notified the oxygen saturation levels were not checked as ordered.</p> <p>2. Review of the clinical record revealed the facility admitted Resident #2 with diagnoses which included COPD.</p> <p>Review of the Physician's Orders, dated October 2011, revealed Resident #2 was to have oxygen at 1 L/m per NC and oxygen saturation was to be assess on room air each shift.</p> <p>Review of the TAR for October 2011 revealed the 11:00 PM to 7:00 AM and the 3:00 PM to 11:00 PM shifts did not complete the assessment for oxygen saturation on room air as ordered.</p> <p>Review of the Nurses Notes revealed no document evidence the Physician was notified the oxygen saturation levels were not checked as ordered.</p> <p>3. Review of the clinical record for Resident #5 revealed the facility admitted the resident with diagnoses which included CHF and COPD.</p> <p>Review of the Physician's Orders, dated October 2011 revealed an order for oxygen at 3 L/m per NC with oxygen saturation checks on room air each shift.</p> <p>Review of the TAR, dated October 2011, revealed the oxygen saturation checks on room air were</p>	F 157	<p>guidelines for physician notification when a resident has an accident resulting in injury, a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly, or a decision to transfer or discharge; or if there is a room change. All nurses were educated on the policy revision on 11-10-11 by the DON. The facility's procedure for "pulse oxymetry readings" during oxygen administration was revised on 11-7-11 by the DON with the approval of the Medical Director and the QA committee on 11-8-11. All nurses were educated on the policy revision on 11-10-11 by the DON. Through the QA process there was a concern identified prior to this abbreviated standard survey with oxymetry. The facility had already hired a QA nurse and the QA nurse was completing orientation on 10/31/11 during the abbreviated survey. One of the responsibilities of the QA nurse is to monitor the TAR/MAR system 5 days weekly to assure that physicians' orders are being completed as ordered, notify physicians if they are not being completed as ordered, and notify the legal responsible party if physicians' orders are not being completed as ordered.</p> <p>4. MAR/TAR audits were initiated on 10/29/11 by the DON and 10/30/11 by the ADON and the QA nurse initiated the audits on 10/31/11. The QA nurse will report to the DON 5 days weekly through written report the results of the QA audits and the</p>	

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F 157	<p>Continued From page 4 and October 2011 revealed the facility failed to complete the checks of oxygen saturation on room air as ordered.</p> <p>Review of the Nurses Notes revealed no document evidence the Physician was notified the oxygen saturation levels were not checked as ordered.</p> <p>Interview, on 10/28/11 at 2:58 PM, with Licensed Practical Nurse (LPN) #4 revealed the physician should be notified if the oxygen saturation check on room air are not completed.</p> <p>In an interview, on 10/28/11 at 3:00 PM, with LPN #2 she stated the Physician needed to be notified when oxygen saturation on room air was not completed.</p> <p>Interview, on 10/28/11 at 4:32 PM, with the Director of Nursing revealed the physician should be notified when three (3) interventions (oxygen saturations checks on room air) were not completed.</p>	F 281	<p>on this same date. For resident #5: the physician was notified by the charge nurse on 11-1-11 that the oxygen saturation levels were not obtained as ordered in October 2011. The physician clarified the order for obtaining oxygen saturation levels on 11-1-11; the resident/legal representative was informed on this same date. For resident #7: the physician was notified by the charge nurse on 10-28-11 that the oxygen saturation levels were not obtained as ordered in October 2011. The physician clarified the order for obtaining oxygen saturation levels on 10-28-11; the resident/legal representative was informed on this same date. For resident #9: the physician was notified by the charge nurse on 10-28-11 that the oxygen saturation levels were not obtained as ordered in July, August, September, and October 2011. The physician clarified the order for obtaining oxygen saturation levels on 10-28-11; the resident/legal representative was informed on this same date.</p> <p>2. The DON and ADON assessed all other residents that have orders for oxygen administration and oxygen saturation levels on 10-28-11 on 2nd shift to assure that physician ordered administration and oxymetry were being followed; all other residents' physicians/legal representatives were notified as appropriate on 10-28-11. As of 10-28-11 all residents with physician ordered oxygen administration and</p>	
F 281 SS=E	<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, record review and review of facility's policy and procedure it was determined the facility failed provide service which met professional standards of quality for five (5) of twelve (12) sampled residents,</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>(Resident #1, #2, #7, #5, and #9). The facility failed to follow Physician's orders to administer Residents #1's and #2's oxygen as ordered. Additionally, the facility failed to monitor oxygen saturation on room air as ordered for Residents #7, #5, and #9.</p> <p>The findings include:</p> <p>Review of the facility's policy "Oxygen Therapy", not dated, revealed the administration and titration of oxygen therapy shall be based on written physicians orders.</p> <p>1. Record review revealed the facility admitted Resident #1 with diagnoses which included Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) with Chronic Carbon Dioxide Retention.</p> <p>Review of the Physician's Orders, dated September and October 2011, for Resident #1 revealed an order for Oxygen at 2 liters/minute (L/m) per Nasal Cannula (NC). Additionally there was an order to check oxygen saturation on room air each shift.</p> <p>Review of the Treatment Administration Record (TAR), dated September and October 2011, revealed the oxygen saturation was not completed as ordered. Per the TAR the nurses initialed and circled the oxygen saturation check, indicating the checks were not completed during the months of September and October for Resident #1.</p> <p>Review of the Nurse's Notes, dated 10/22/11 at 7:15 PM, revealed Resident #1's oxygen flow rate</p>	F 281	<p>oxymetry were being appropriately followed. The DON did verbal on-the-spot re-education to charge nurses present regarding following MD orders. No residents were negatively affected by not having the accurate oxygen administration flow rate or oxymetry completed as ordered.</p> <p>3. Through the QA process there was a concern identified prior to this abbreviated standard survey with oxymetry. The facility had already hired a QA nurse and the QA nurse was completing orientation on 10/31/11 during the abbreviated survey. One of the responsibilities of the QA nurse is to monitor the TAR/MAR system 5 days weekly to assure that physicians' orders are being completed as ordered, notify physicians if they are not being completed as ordered, and notify the legal responsible party if physicians' orders are not being completed as ordered. The charge nurses were re-educated on 10-28-11 by the DON regarding monitoring oxygen concentrators for flow rate accuracy which is to be completed at least once a shift by the charge nurse. A mandatory in-service for all nurses and KMA's was conducted on</p>	
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F 281	<p>Continued From page 6</p> <p>was adjusted from 5 L/m to 3 L/m, after a family member brought the error to the nurse's attention.</p> <p>2. Review of the clinical record revealed the facility admitted Resident #2 with diagnoses which included COPD.</p> <p>Review of the Physician's Orders, dated October 2011, revealed an order for oxygen at 1 L/m per NC with a start date of 07/30/11. Additionally, the orders detailed the resident's oxygen saturation was to be assessed on room air each shift.</p> <p>Review of the TAR for Resident #2, dated October 2011, revealed the oxygen saturation was not assessed on room air as ordered by the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts.</p> <p>Observations, on 10/27/11 at 11:42 AM, 1:05 PM, 2:05 PM, 3:07 PM, 4:14 PM and 5:23 PM, revealed the resident was sitting in the wheelchair with no oxygen therapy in place.</p> <p>Interview, on 10/28/11 at 4:32 PM, with the Director of Nursing revealed the physician's order for Resident #2 was for oxygen to be administered at 1 L/m per NC continuously.</p> <p>Observations, on 10/27/11 at 10:02 AM and 10:50 AM, revealed the resident was sitting in the wheelchair and the oxygen flow rate was set at 4.5 L/m per NC.</p> <p>Observation, on 10/28/11 at 9:25 AM, revealed the resident was sitting in the wheelchair with the oxygen flow rate set at 4 L/m per NC.</p>	F 281	<p>11/10/11 by Risk Management Solutions (RN/BSN) regarding Managing risks through documentation and the objectives included professional standards related to documentation (See attached list of objectives). This in-service has been added to the orientation process for all new nurses and KMA's. All SRNA's were re-educated on accuracy and completeness of documentation on 10/31/11 by the DON.</p> <p>4. MAR/TAR audits were initiated on 10/29/11 by the DON and 10/30/11 by the ADON and the QA nurse initiated the audits on 10/31/11. The QA nurse will report to the DON 5 days weekly through report the results of the QA audits and the QA nurse will report the results of the MAR/TAR audits to the QA committee by report at the weekly QA meeting. The DON will designate another nurse to perform the MAR/TAR audits the two days that the QA nurse is not working and the designated nurse will report the audit results to the DON. The audits will be completed daily x30 days and then weekly once acceptable compliance is met. Any deviation from the policies/procedures will result in disciplinary actions and re-education of the nurses involved.</p>	Completion Date: 11-11-11

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F 281	<p>Continued From page 7</p> <p>Interview, on 10/28/11 at 9:25 AM, the Assistant Director of Nursing revealed Resident #1's flow rate was not set correctly and the physician would need to clarify the order.</p> <p>3. Review of the clinical record for Resident #6 revealed the facility admitted the resident with diagnoses which included CHF and COPD.</p> <p>Review of the Physician's Orders, dated October 2011 revealed an order for oxygen at 3 L/m per NC with oxygen saturation checks on room air each shift.</p> <p>Review of the TAR, dated October 2011, revealed the oxygen saturations on room air were not completed as ordered.</p> <p>4. Review of the clinical record revealed the facility admitted Resident #7 with diagnoses which included CHF and Anxiety.</p> <p>Review of the Physician's Orders, dated October 2011, revealed the resident was to receive oxygen at 2 L/m per NC and orders to assess oxygen saturation on room air each shift.</p> <p>Review of the TAR for October 2011 revealed the nurses had initialed and circled their initials which indicated the oxygen checks had not been completed.</p> <p>5. Review of the clinical record for Resident #9 revealed the facility admitted the resident with diagnoses which included Aspiration Pneumonia and Anxiety.</p> <p>Review of the Physician's Orders dated July,</p>	F-328	<p>1. For resident #1: the physician was notified by the charge nurse on 10-28-11 that the oxygen saturation was not obtained as ordered in September and October, 2011 and that on 10/22/11, the oxygen flow rate was at 5LPM instead of the ordered rate. The resident/legal representative was aware of the flow rate error at the time it occurred. For resident #2: the physician was notified by the charge nurse on 11-1-11 that the oxygen saturation was not obtained as ordered in October 2011 and that the resident had been receiving oxygen continuously as ordered on a continuous basis and that the oxygen flow rate was not administered as ordered on 10/27/11 and 10/28/11. The physician clarified the order for oxygen administration and for obtaining oxygen saturation levels on 11-1-11, the resident/legal representative was informed on this same date. For resident #5: the physician was notified by the charge nurse on 11-1-11 that the oxygen saturation levels were not obtained as ordered in October 2011. The physician clarified the</p>	

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F 281	<p>Continued From page 8</p> <p>August, September and October 2011 revealed an order to for oxygen at 2 L/m per NC with checks of oxygen saturation on room air each shift.</p> <p>Review of the TAR for July, August, September, and October 2011 revealed the facility failed to complete the checks of oxygen saturation on room air as ordered.</p> <p>Interview, on 10/28/11 at 2:58 PM, with Licensed Practical Nurse (LPN) #4 revealed if the resident did not have oxygen off during the shift she did not not complete the assessment of oxygen saturation on room air. LPN #4 stated all physiolan's order should be followed related to oxygen.</p> <p>In an interview, on 10/28/11 at 3:00 PM, with LPN #2, oxygen saturation on room air should be taken as ordered if on the TAR and physician's order sheet.</p> <p>Interview, on 10/28/11 at 4:10 PM with LPN #5 revealed the physician should be contacted to obtain new orders if the oxygen saturation on room air was not being completed.</p> <p>Interview, on 10/28/11 at 4:32 PM, with the Director of Nursing revealed the physician should be notified when oxygen saturations on room air were not completed. (Refer to F157).</p>	F 328	<p>order for obtaining oxygen saturation levels on 11-1-11; the resident/legal representative was informed on this same date. For resident #7: the physician was notified by the charge nurse on 10-28-11 that the oxygen saturation levels were not obtained as ordered in October 2011. The physician clarified the order for obtaining oxygen saturation levels on 10-28-11; the resident/legal representative was informed on this same date. For resident #9: the physician was notified by the charge nurse on 10-28-11 that the oxygen saturation levels were not obtained as ordered in July, August, September, and October 2011. The physician clarified the order for obtaining oxygen saturation levels on 10-28-11; the resident/legal representative was informed on this same date.</p> <p>2. The DON and ADON assessed all other residents that have orders for oxygen administration and oxygen saturation levels on 10-28-11 on 2nd shift to assure that physician ordered administration and oxymetry were being followed; all other residents' physicians/legal representatives were notified as appropriate on 10-28-11. As of 10-28-11, all residents with physician ordered oxygen administration and oxymetry were being appropriately followed. No residents were negatively affected by not having the accurate oxygen administration flow rate or oxymetry completed as ordered.</p>	
F 328 SS=E	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:</p>			

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F 328	<p>Continued From page 9</p> <p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy and procedure it was determined the facility failed provide proper treatment for the special service of respiratory care for five (5) of twelve (12) sampled residents, (Resident #1, #2, #7, #9, and #5). The facility failed to administer Residents #1's and #2's oxygen as ordered. Additionally, the facility failed to monitor oxygen saturation on room air each shift as ordered for Residents #1, #2, #5, #7, and #9.</p> <p>The findings include:</p> <p>Review of the facility's policy "Oxygen Therapy", not dated, revealed the administration and titration of oxygen therapy shall be based on written physicians orders.</p> <p>1. Per the clinical record Resident #1 was admitted to the facility with diagnoses which included Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) with Chronic Carbon Dioxide Retention.</p>	F 328	<p>3. . Through the QA process there was a concern identified prior to this abbreviated standard survey with oxymetry. The facility had already hired a QA nurse and the QA nurse was completing orientation on 10/31/11 during the abbreviated survey. One of the responsibilities of the QA nurse is to monitor the TAR/MAR system 5 days weekly to assure that physicians' orders are being completed as ordered, notify physicians if they are not being completed as ordered, and notify the legal responsible party if physicians' orders are not being completed as ordered. The charge nurses were re-educated on 10-28-11 by the DON regarding monitoring oxygen concentrators for flow rate accuracy which is to be completed at least once a shift by the charge nurse. A mandatory in-service for all nurses and KMA's was conducted on 11/10/11 by Risk Management Solutions (RN/BSN) regarding Managing risks through</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/28/2011
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE- 109 RODGERS PARK CYNTHIANA, KY 41031	
(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 328	<p>Continued From page 10</p> <p>Review of the Physician's Orders, dated September and October 2011, for Resident #1 revealed an order for Oxygen at two (2) liters/minute (L/m) per Nasal Cannula (NC). Additionally there was an order to check oxygen saturation on room air each shift.</p> <p>Review of the Treatment Administration Record (TAR), dated September and October 2011, revealed the oxygen saturation checks were not completed as ordered. Per the TAR the nurses initialed and circled the oxygen saturation check, indicating the checks were not completed during the months of September and October for Resident #1.</p> <p>Review of the Nurse's Notes, dated 10/22/11 at 7:15 PM, revealed Resident #1's oxygen flow rate was adjusted from 5 L/m to 3 L/m, after a family member brought the error to the nurse's attention.</p> <p>2. Review of the clinical record revealed the facility admitted Resident #2 with diagnoses which included COPD.</p> <p>Review of the Physician's Orders, dated October 2011, revealed an order for oxygen at 1 L/m per NC with a start date of 07/30/11. Additionally, the orders detailed the resident's oxygen saturation was to be assessed on room air each shift.</p> <p>Review of the TAR for Resident #2, dated October 2011, revealed the oxygen saturation was not assessed on room air as ordered by the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts.</p> <p>Observations, on 10/27/11 at 10:02 AM and 10:50</p>	F 328	<p>documentation and the objectives included professional standards related to documentation and regulations that govern documentation in long-term care (See attached list of objectives). This in-service has been added to the orientation process for all new nurses and KMA's.</p> <p>4. MAR/TAR audits were initiated on 10/29/11 by the DON and 10/30/11 by the ADON and the QA nurse initiated the audits on 10/31/11. The QA nurse will report to the DON 5 days weekly through written report the results of the QA audits and the QA nurse will report the results of the MAR/TAR audits to the QA committee by report at the weekly QA meeting. The DON will designate another nurse to perform the MAR/TAR audits the two days that the QA nurse is not working and the designated nurse will report the audit results to the DON. The audits will be completed daily x30 days and then weekly once acceptable compliance is met. The DON or QA nurse will monitor documentation to assure compliance to treatment/care of special needs resident conditions weekly x4 and then monthly thereafter until substantial compliance is met and the results of the monitoring will be presented to the QA committee during the weekly QA meetings. Any deviation from the policies/procedures or deviation from special treatment/care of special needs residents will result in disciplinary actions and re-education of the nurses involved.</p>	Completion Date: 11-11-11

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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F 328	<p>Continued From page 11</p> <p>AM, revealed the resident was sitting in the wheelchair and the oxygen flow rate was set at 4.6 L/m per NC.</p> <p>Observation, on 10/28/11 at 9:25 AM, revealed the resident was sitting in the wheelchair with the oxygen flow rate set at 4 L/m per NC.</p> <p>Interview, on 10/28/11 at 9:25 AM, with LPN #5 revealed Resident #1's flow rate was not set correctly and the physician would need to clarify the order.</p> <p>Observations, on 10/27/11 at 11:42 AM, 1:05 PM, 2:05 PM, 3:07 PM, 4:14 PM and 5:23 PM, revealed the resident was sitting in the wheelchair with no oxygen therapy in place.</p> <p>Interview, on 10/28/11 at 4:32 PM, with the Director of Nursing revealed the physician's order for Resident #2 was for oxygen to be administered at 1 L/m per NC continuously.</p> <p>3. Review of the clinical record for Resident #5 revealed the facility admitted the resident with diagnoses which included CHF and COPD.</p> <p>Review of the Physician's Orders, dated October 2011 revealed an order for oxygen at 3 L/m per NC with oxygen saturation checks on room air each shift.</p> <p>Review of the TAR, dated October 2011, revealed the oxygen saturations on room air were not completed as ordered.</p> <p>4. Review of the clinical record revealed the facility admitted Resident #7 with diagnoses</p>	F-514	<p>1. For resident #1: the physician was notified by the charge nurse on 10-28-11 that the oxygen saturation was not obtained as ordered in September and October, 2011 and that on 10/22/11, the oxygen flow rate was at 5LPM instead of at 3LPM. The resident/legal representative was aware of the flow rate error at the time it occurred. For resident #2: the physician was notified by the charge nurse on 11-1-11 that the oxygen saturation was not obtained as ordered in October 2011 and that the resident had been receiving oxygen continuously as ordered on a continuous basis and that the oxygen flow rate was not administered as ordered on 10/27/11 and 10/28/11. The physician clarified the order for oxygen administration and for obtaining oxygen saturation levels on 11-1-11, the resident/legal representative was informed on this same date. For resident #5: the physician was notified by the charge nurse on 11-1-11 that the oxygen saturation levels were not obtained as ordered in October 2011. The physician clarified the order for obtaining oxygen saturation levels on 11-1-11, the resident/legal representative was informed on this same date. For resident #7: the physician was notified by the charge nurse on 10-28-11 that the oxygen saturation levels were not obtained as ordered in October 2011. The physician clarified the order for obtaining oxygen saturation levels on 10-28-11, the</p>	

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F 328	<p>Continued From page 12 which included CHF and Anxiety.</p> <p>Review of the Physician's Orders, dated October 2011, revealed the resident was to receive oxygen at 2 L/m per NC. Additionally, there were orders to check Resident #7's oxygen saturation on room each shift.</p> <p>Review of the TAR for October 2011 revealed the nurses had initialed and circled their initials which indicated the oxygen checks had not been completed.</p> <p>5. Review of the clinical record for Resident #9 revealed the facility admitted the resident with diagnoses which included Aspiration Pneumonia and Anxiety.</p> <p>Review of the Physician's Orders, dated July, August, September and October 2011, revealed an order to for oxygen at 2 L/m per NC with checks of oxygen saturation on room air each shift.</p> <p>Review of the TAR for July, August, September, and October 2011 revealed the facility failed to complete the checks of oxygen saturation on room air as ordered.</p> <p>Interview, on 10/28/11 at 2:56 PM, with Licensed Practical Nurse (LPN) #4 revealed if the resident did not have oxygen off during the shift she did not not complete the assessment of oxygen saturation on room air. LPN #4 stated all physician's order should followed related to oxygen.</p> <p>In an interview, on 10/28/11 at 3:00 PM, with LPN</p>	F514	<p>resident/legal representative was informed on this same date. For resident #9: the physician was notified by the charge nurse on 10-28-11 that the oxygen saturation levels were not obtained as ordered in July, August, September, and October 2011. The physician clarified the order for obtaining oxygen saturation levels on 10-28-11, the resident/legal representative was informed on this same date.</p> <p>2. The DON and ADON assessed all other residents that have orders for oxygen administration and oxygen saturation levels on 10-28-11 on 2nd shift to assure that physician ordered administration and oxymetry were being followed; all other residents' physicians/legal representatives were notified as appropriate on 10-28-11. As of 10-28-11 all residents with physician ordered oxygen administration and oxymetry were being appropriately followed. No residents were negatively affected by not having the accurate oxygen administration flow rate or oxymetry completed as ordered.</p> <p>3. Through the QA process there was a concern identified prior to this abbreviated standard survey with oxymetry. The facility had already hired a QA nurse and the QA nurse was completing orientation on 10/31/11 during the abbreviated survey. One of the responsibilities of the QA nurse is to monitor the TAR/MAR system 5 days</p>	
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F 328	<p>Continued From page 13</p> <p>#2 oxygen saturation on room air should be taken as ordered if on the TAR and physician's order sheet.</p> <p>Interview, on 10/28/11 at 4:10 PM with LPN #5 revealed the physician should be contacted to obtain new orders if the oxygen saturation on room air was not being completed.</p> <p>Interview, on 10/28/11 at 4:32 PM, with the Director of Nursing revealed the physician should be notified when oxygen saturations on room air were not completed. (Refer to F157 and F281).</p>	F 514	<p>weekly to assure that physicians' orders are being completed as ordered, notify physicians if they are not being completed as ordered, and notify the legal responsible party if physicians' orders are not being completed as ordered, and to assure appropriate documentation is completed if a treatment/medication/procedure is not completed. The charge nurses were re-educated on 10-28-11 by the DON regarding monitoring oxygen concentrators for flow rate accuracy which is to be completed at least once a shift by the charge nurse. A mandatory in-service for all nurses and KMA's was conducted on 11/10/11, by Risk Management Solutions (RN/BSN) regarding Managing risks through documentation and the objectives included professional standards related to documentation and regulations that govern documentation in long-term care (See attached list of objectives). This in-service has been added to the orientation process for all new nurses and KMA's.</p>	
F 514 SS#E	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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 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: Based on interview, record review and review of facility's policy and procedure it was determined the facility failed to maintain clinical records with accepted professional standards and practices that were accurate and complete for five (5) of</p>			

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F 514	<p>Continued From page 14</p> <p>twelve (12) sampled residents, (Resident #1, #2, #5, #7, and #9). The facility failed to document the rationale for its failure to assess residents' oxygen saturation on room air.</p> <p>The findings include:</p> <p>Review of the facility's policy "Oxygen Therapy", not dated, revealed the administration and titration of oxygen therapy shall be based on written physicians orders.</p> <p>Review of the clinical record for Resident #1, #2, #5, #7 and #9 revealed a physician's order to assess the residents oxygen saturation on room air each shift.</p> <p>Review of the Treatment Administration Records (TARs) for Residents #1, #2, #5, #7, and #9 revealed no documented evidence facility staff completed assessments of oxygen saturation on room air each shift. Additional review of the TARs revealed no documentation as to why staff failed to complete assessments of oxygen saturation on room air.</p> <p>Interview, on 10/28/11 at 2:56 PM, with Licensed Practical Nurse (LPN) #4 revealed If the resident did not have oxygen off during the shift she did not not complete the assessment of oxygen saturation on room air. LPN #4 stated all physician's order should followed related to oxygen.</p> <p>In an interview, on 10/28/11 at 3:00 PM, with LPN #2 revealed oxygen saturation on room air should be taken as ordered and documented on the TAR.</p>	F 514	<p>4. MAR/TAR audits were initiated on 10/29/11 by the DON and 10/30/11 by the ADON and the QA nurse initiated the audits on 10/31/11. The QA nurse will report to the DON 5 days weekly through report the results of the QA audits and the QA nurse will report the results of the MAR/TAR audits to the QA committee by report at the weekly QA meeting. The DON will designate another nurse to perform the MAR/TAR audits the two days that the QA nurse is not working and the designated nurse will report the audit results to the DON. The audits will be completed daily x30 days and then weekly once acceptable compliance is met. Any deviation in appropriate maintenance of clinical records with acceptable professional standard and practices including accuracy and completeness will result in disciplinary action and re-education of the nurses involved.</p>	F-514 Completion Date: 11-11-11.
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F 514	<p>Continued From page 15</p> <p>Interview, on 10/28/11 at 4:10 PM with LPN #5 revealed the physician should be contacted to obtain new orders if the oxygen saturation on room air was not being completed. Additionally, the LPN stated staff was to document on the TAR the reason oxygen saturations were not taken, if they were not taken.</p> <p>Interview, on 10/28/11 at 4:32 PM, with the Director of Nursing revealed the physician should be notified when oxygen saturation on room air were not completed. (Refer to F157, F281 and F328).</p>	F 514		