

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

PRINTED: 03/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/21/2014
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NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
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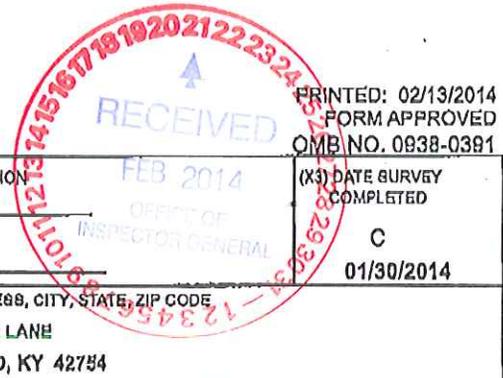
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 02/21/14 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS An Abbreviated Survey Investigating #KY21228 was conducted on 01/29/14 through 01/30/14 to determine the facility's compliance with Federal requirements. #KY21228 was substantiated with deficiencies cited at the highest scope and severity of a "E".	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or Ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of respiratory physician orders, respiratory flow sheets, nurse aide data sheets, Minimum Data Set (MDS) assessments, care plans, and the facility's "Oxygen Management" policy/procedure, it was determined the facility failed to ensure two (2) of four (4) sampled residents (Resident #2 and Resident #4) received respiratory care. The facility failed to ensure Resident #2's and Resident #4's portable oxygen (O2) concentrators had O2 in them.	F 328	F328 <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #2 was assessed by Licensed staff on 01/29/14 for signs and symptoms of respiratory distress and none were identified. Resident #4 was assessed by Licensed staff on 01/29/14 for signs and symptoms of respiratory distress and none were identified. <u>How other residents who may have been affected by this practice were identified:</u> All resident receiving respiratory care via portable O2 tanks and concentrators were assessed for signs and symptoms of respiratory distress and none were identified. All residents utilizing portable O2 tanks and concentrators had their equipment assessed to ensure portable O2 tanks and concentrators were at 50% or higher any identified as less than 50% were refilled immediately by staff.	02/21/14

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NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 715 GOODWIN LANE LEITCHFIELD, KY 42764	
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F 328	Continued From page 1 The findings include: Review of the facility policy titled, "Oxygen Management", dated 10/24/12, revealed "all liquid companion tanks will be filled by the assigned staff member/shift. When transferring from concentrator to companion, check level. If less than 50%, fill prior to connecting to companion tank. Leave cannula connected to the concentrator while filling. Check for Oxygen tank level when repositioning, during care, prior to transports, or every 2 hours, whichever is less. Turn off oxygen when not in use and secure tubing. Oxygen saturations to be assessed each shift, and as indicated, based on clinical assessment unless otherwise ordered by physician. Residents who are stable may require less frequent monitoring. Oxygen E cylinder duration times, one (1) Liter per minute = eight (8) hours, 1.5 liters per minutes = five (5) hours, two (2) liters per minute = four (4) hours, 2.6 liters per minute = three (3) hours, three (3) liters per minute = two (2) hours, four (4) liters per minute = two (2) hours, five (5) liters per minute = 1 3/4 hours. Oxygen tanks should be changed when the needle is in the red area (below 500 psi) 1. Record review revealed Resident #2 was admitted to the facility on 05/01/13 with diagnoses which included Chronic Airway Obstruction, Congestive Heart Failure (CHF), Edema, and difficulty in walking, and muscle weakness. Review of the quarterly Minimum Data Set (MDS), dated 01/10/14, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Intermittent Mental Status (BIMS) score of a "10". The resident required extensive assistance with activities of daily living (ADLs) and required oxygen.	F 328	F 328 <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> All Nursing Staff re-educated by Director of Nursing on 02/01/14 on policy of oxygen management. Resident requiring utilization of O2 delivered via concentrator and or portable O2 tank will have gauges assessed every 2 hours to ensure levels are maintained at 50% or higher. Director of Nursing will QI monitor concentrators and portable oxygen tanks every shift 5days per week x 4 weeks then weekly x 2 months to ensure to ensure O2 levels is 50% or more. Any variance will be addressed immediately through re-education. <u>Monitoring for Ongoing Compliance:</u> Findings of the QI monitoring will be brought by the Director of Nursing to the QAPI meeting monthly x 3 months for review and development of action plan to ensure residents receive proper treatment and care receiving respiratory care.	02/21/14

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F 328	<p>Continued From page 2</p> <p>Review of Resident #2's January 2014 respiratory physician orders revealed the resident should receive continuous O2 at 2-4 liters per minute (l/m) per nasal cannula (N/C).</p> <p>Review of Resident #2's Comprehensive Care Plan for CHF, dated 05/16/13, revealed the resident was at risk for complications with an intervention to administer O2 as ordered. Review of the Nurse Aide Data Sheet, dated 11/19/13, revealed O2 at 2-4 l/m continuous per NC.</p> <p>Observation, on 01/28/14 at 5:31 PM, revealed Resident #2's was sitting in a chair with the O2 per N/C at 2 l/m. Further observation of the portable O2 concentrator revealed it was in the red zone and empty. Interview with the ADON who was present at the time revealed the portable tank for Resident #2 was empty.</p> <p>Interview, on 01/30/14 at 4:40 PM with Resident #2, revealed he/she felt "whoooooee, dizzy" before the O2 tank was filled up.</p> <p>Review of the January 2014 Respiratory Flow Sheet revealed O2 at 2-4 l/m per N/C continuous and to check O2 concentrator every two hours, replace as needed. Further review revealed the last time it was initialed to indicate the O2 had been checked was 4:00 PM.</p> <p>Interview with Registered Nurse (RN) #1, on 01/30/14 at 5:04 PM, revealed she had initialed Resident #2's portable tank had been checked for O2 on 1/28/14 at 4:00 PM. The RN stated she could not remember how much oxygen was in the tank, but the resident's tank usually lasts 6-8 hours. The RN revealed if the tank had been less</p>	F 328			

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F 328	<p>Continued From page 3</p> <p>than 1/2 full, she would have filled it up. She stated she does not trust the tank if it is below 1/3 full.</p> <p>Interview, on 01/28/14 at 5:31 PM with the Assistant Director of Nursing (ADON), revealed it should be on Medication Administration Record (MAR) to check and see if not empty every two (2) hours (Q2H).</p> <p>2. Record review revealed the facility admitted Resident #4 on 08/18/13 with diagnoses which included Aspiration Syndrome, Neuropathy, Chronic Heart Disease, Chronic Edema, Dementia, and muscle weakness. Review of quarterly MDS, dated 01/27/14, revealed the facility assessed Resident #4's cognition as moderately impaired with a BIMS of "8". The resident required extensive assist with ADL's and oxygen.</p> <p>Review of the January 2014 respiratory physician orders revealed Resident #4 should received O2 at 2 l/m per N/C to keep O2 saturation levels greater than 90%.</p> <p>Review of the Comprehensive Care Plan for increased risk for cardiovascular complication and risk for Impaired gas exchange, dated 11/14/13, revealed interventions to administer medications as ordered per physician and administer O2 at 3 l/m via NC, as needed.</p> <p>Observation, on 1/30/14 at 4:48 PM, revealed Resident #4 was transported by staff to the dining room per his/her wheelchair with no O2 concentrator on the chair. CNA #1 was observed walking at the time down the hall with a portable O2 concentrator. Interview with the Certified</p>	F 328		

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F 328	<p>Continued From page 4</p> <p>Nurse Aide (CNA) #1, at the time, revealed she was going to fill up Resident #4's portable O2 concentrator because it was empty.</p> <p>Interview on 1/30/14 at 4:51 PM with Resident #4 In dining room revealed he/she was sleepy.</p> <p>Review of the January 2014 respiratory flow sheet revealed there was no documentation to show the resident's O2 concentrator should be checked for the amount of O2.</p> <p>Interview, on 01/30/14 at 4:54 PM with Licensed Practical Nurse (LPN) #2, revealed she had not checked Resident #4's O2 tank yet, and the last time it was checked was probably around 2:00 PM. LPN #2 further revealed Resident #4 did not have two (2) hour checks of O2 concentrator written on his/her respiratory flow sheet.</p> <p>Interviews with CNA #3, CNA #5, CNA #9 and CNA #13, on 01/30/14 at 10:48 AM, 11:30 AM, 11:46 AM, and 12:08 PM, revealed only the nurses were able to refill the portable O2 concentrators.</p> <p>Interview on 01/30/14 at 11:50 AM with Registered Nurse (RN) #2 revealed the nurse fills the O2 tanks but all staff needs to look at them.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 01/30/14 at 3:01 PM, revealed the nurses were to fill the portable O2 concentrators and the CNAs can fill them if they have been inserviced.</p> <p>Interview, on 01/30/14 at 2:15 PM with Director of Nursing (DON), revealed all staff should monitor to ensure the O2 nasal cannula was in place on</p>	F 328		

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F 328	Continued From page 5 the resident's nose and the portable O2 concentrator is on. She stated it was on the Treatment Administration Record (TAR) to check the portable O2 concentrators every two (2) hours to ensure in place, on and the amount of O2 in the concentrator. The DON stated all nursing staff can refill the O2 concentrators if they are empty.	F 328		
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 hand washing is indicated by accepted	F 441	F441 <u>Corrective Measures for Resident Identified in the deficiency:</u> Nebulizer tubing and face pieces in room #204 and 213 were discarded by Director of Nursing on 01/31/14. They were replaced with new dated tubing and face piece and stored in plastic bag. Nebulizer tubing and face piece in room 216 was discarded by Director of Nursing on 01/31/14. They were replaced with new dated tubing and face piece and stored in plastic bag. O2 tubing in room 112 was discarded by Director of Nursing on 01/31/14 and replaced with new dated tubing. Stored in plastic bag when not in use. The O2 concentrator was set on current physician ordered settings. Nasal Cannula and tubing in room 114 was discarded by Director of Nursing on 01/31/14. They were replaced with new dated tubing and nasal cannula. The nebulizer tubing and face piece was discarded at same time as nasal cannula and replaced with new tubing and face piece and placed in plastic bag.	02/21/14

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F 441	<p>Continued From page 6 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, staff interview, and review of the facility policy it was determined the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to ensure nebulizer and Oxygen (O2) tubing and masks were stored covered when not in use in rooms #105, 108, 109, 112, 114, 204, 213, and 216. In addition, the facility failed to ensure the nebulizer equipment was cleaned prior to storage after use.</p> <p>The findings include:</p> <p>Review of the facility policy for Infection Prevention and Control, dated 09/2011, revealed the facility was to provide a safe, sanitary, and comfortable environment. This facility will investigate, control, and attempt to prevent the development and transmission of infections. The facility will provide precautionary measures to prevent the spread of potential infection, while monitoring resident's progress.</p> <p>Review of the facility policy titled "Oxygen Therapy Concentrator Set-up", dated 01/01/2007, revealed cannulas, masks, or other delivery</p>	F 441	<p>F441</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p>The nebulizer hose, face mask, nasal cannula and tubing in room 109 was discarded by Director of Nursing on 01/31/14 and replaced with new nebulizer hose, face mask, nasal cannula and tubing and placed in plastic bag In room 106 the O2 concentrator hose and face piece was discarded by Director of Nursing on 01/31/14 and replaced with new dated O2 tubing and nasal cannula stored in plastic bag. In room 105 the nebulizer tubing and face piece was discarded by Director of Nursing on 01/31/14 and replaced with new dated tubing and face piece stored in plastic bag. Residents identified were assessed by ID team to ensure residents were free of respiratory infections, MD was notified as indicated. Comprehensive care-plans and nurse aid data sheets reviewed/revised as indicated.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>All residents receiving O2 therapy and nebulizer treatments were assessed by ID team for any signs and symptoms of</p>	02/21/14

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F 441	<p>Continued From page 7</p> <p>device should be stored in a plastic bag or container when not in use to decrease the risk of contamination.</p> <p>1. Observations on 1/28/14 from 4:25 PM through 6:10 PM revealed:</p> <p>A. In room #204 and room #213, the nebulizer tubing and face piece were not stored in a plastic bag and were lying on the bedside table,</p> <p>B. In room #216, the nebulizer tubing and face piece were not stored in a plastic bag and were lying on the over bed table.</p> <p>C. In room #112, the O2 tubing were not stored in a bag and were on the bed with the O2 concentrator unit running at six (6) liters a minute.</p> <p>D. In room #114, the oxygen nasal cannula and tubing were not stored in a plastic bag and were on the floor and the nebulizer tubing and face piece were not secured in plastic bag and were on the floor.</p> <p>E. In room #109, the nebulizer hose and face piece were not secured in a plastic bag lying on top of chest drawers. In addition, there was a nasal cannula and tubing, dated 12/19/13, that was hanging out of the top drawer of chest drawers.</p> <p>F. In room #106, the portable O2 concentrator hose and face piece were not stored in a bag and were laying in a wheelchair.</p> <p>G. In room #106, the nebulizer tubing and face piece were not secured in a plastic bag and were laying on the bedside table.</p> <p>Interviews on 01/28/14 at 5:21 PM, on 01/29/14 at 9:06 AM and on 1/30/14 at 10:20 AM, 10:59 AM, 10 48 AM, 11:48 AM, 12:06 PM, 1:04 PM and 2:56 PM with LPN #1, LPN #4, LPN #6, LPN #7, CMA #3, CMA #4 and CNA #1, CNA #2 and CNA</p>	F 441	<p>F441</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>respiratory distress/infection. MD notified as indicated, and comprehensive care plan, nurse aid data sheets reviewed/revised as indicated.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All Nursing staff re-educated on storage of nebulizer equipment, oxygen equipment and cleaning of nebulizer equipment following use by the Director of Nursing on 02/01/14. Director of Nursing will QI monitor placement of nebulizer equipment and oxygen equipment for storage, cleaning, and dating 3x per day x 5 days for 1 week then 2 x per day x 5 days for 1 week then daily x 5 days x 1 week then weekly x 2 months then quarterly. Any variances will be addressed immediately through re-education.</p> <p><u>Monitoring for Ongoing Compliance:</u></p> <p>Findings will be brought to the QAPI meeting for review and development of action plan to ensure O2 and nebulizer</p>	02/21/14

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F 441	Continued From page 8 #3 revealed oxygen equipment should be stored in a plastic bag when not in use. Interview, on 0 1/30/14 at 2:15 PM with Director of Nursing (DON), revealed oxygen equipment should be stored in a plastic bag when not in use. 2. Observation on 01/29/14 at 12:13 PM of a nebulizer treatment to Resident #2 revealed Registered Nurse (RN) #2 emptied the nebulizer reservoir and put nebulizer reservoir back in the plastic bag on the over the bed table without washing the equipment after the treatment. Interview, on 01/29/14 at 12:20 PM with RN #1, revealed she did not wash out the nebulizer after giving Resident #2's treatment and she should have to prevent the sputum from sitting and bacteria from growing in it. Interview, on 01/30/14 at 2:15 PM with the DON revealed he reservoir of nebulizer should have been washed out, dried and then placed back where it belonged.	F 441	F441 <u>Monitoring for Ongoing Compliance:</u> equipment is maintained in a safe and sanitary manner to prevent developmet/transmission of disease.	02/21/14