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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185015	A. BUILDING B. WING	C 07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MADISONVILLE	419 NORTH SEMINARY ST MADISONVILLE, KY 42431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey (KY #18791) was initiated on 07/25/12 and concluded on 07/26/12 to determine the facility's compliance with Federal requirements. KY #18791 was substantiated with deficiencies cited.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure each resident's care plan was revised for two residents (#1 and #2), in the selected sample of three residents, related to the use of an	F 280	F 280 It is the policy of NHC Madisonville for each resident, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, to participate in planning care and treatment or changes in care and treatment. Resident # 1 no longer has an accessed Mediport site. Overseen by the Director of Nursing the current care plan was updated to reflect care of an un-accessed site on 07/26/12. Overseen by the Director of Nursing, resident # 2's care plan was updated to address the administration of IV fluids on 07/30/12. Overseen by the Director of Nursing, an audit of all residents with peripheral and Mediport IV access sites was conducted on 07/27/12. Currently all residents with peripheral and Mediport IV access sites have a care plan in place to reflect the care required specific to the device being utilized.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Danny Bilchin	adm	8/16/12

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 280	Continued From page 1 Intravascular (IV) Access Device or Mediport. The facility failed to revise the comprehensive care plan related to administration of flushes before and after antibiotics, as well as dressing changes for Resident #1, and failed to revise Resident #2's care plan to include the physician ordered IV fluids. Findings include: The facility did not have a specific policy for care plans. 1. A record review revealed Resident #1 was admitted on 04/14/05 with diagnoses to include Cerebrovascular Accident (CVA), Coronary Artery Disease (CAD), History of Cancer, and an Implanted Mediport Device. A review of the significant change Minimum Data Set (MDS) assessment, dated 07/16/12, revealed the facility identified Resident #1 as moderately cognitively impaired and totally dependent on staff members for all care needs. A record review revealed the facility transferred Resident #1 to the hospital on 06/22/12 with Pneumonia and discharged back to the facility on 06/26/12 with discharge instructions for IV antibiotics to continue the Mediport for an additional five days, to end on 07/01/12 at 1:00 AM. A review of the physician's order, dated 06/26/12, revealed orders for IV antibiotics for five days, to end on 07/01/12 at 1:00 AM. The order did not address the need for flushing or dressing changes.	F 280	Overseen by the Director of Nursing the facility developed acute care plans for peripheral and Mediport IV access devices. All licensed nursing staff received in-service education and training by the Director of Nursing on 07/26/12, 07/31/12, 08/03/12, and 08/06/12 regarding initiation of acute care plans for peripheral and Mediport IV access devices. Overseen and monitored by the Director of Nursing a Quality Assurance study of the center's compliance of acute care plans with peripheral and Mediport IV access devices will be conducted monthly x 2 beginning in September 2012. The findings will be reported to the Quality Assurance committee. The monitoring and training will be continued by the DON or as directed by the Quality Assurance Committee.	8/7/2012

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F 280	Continued From page 2 A review of the resident's care plan, "At risk for infection, related to the use of a Mediport, to the left chest area," reviewed on 07/13/12, revealed the site was to be observed for redness and irritation and the staff were to intervene, as indicated; the resident was to go to the hospital, once a month for flushes; and the staff were to observe the resident for any signs of infection or bleeding. The care plan did not address the physician ordered IV fluids. There was no evidence that the facility had revised the care plan to include Heparin and Normal Saline flushes or dressing changes to the port that were required when the physician ordered IV antibiotics to be administered, on 06/26/12, after the resident returned from the hospital. An observation of a skin assessment conducted on Resident #1, with LPN #1, on 07/26/12 at 10:20 AM, revealed the resident resting quietly in bed with a small Band-Aid to the left upper chest area. The Band-Aid was removed to reveal a nickle-sized, raised area, where the skin covered the implanted Mediport device. A small red dot, near the center of the port, was the only redness noted to the site. An interview with Licensed Practical Nurse (LPN) #1, on 07/26/12 at 10:17 AM, revealed the resident finished the required rounds of antibiotics, on 07/25/12. The red dot was the result of the Huber Needle that had been removed along with the transparent dressing after the last round of antibiotics. LPN #1 stated the resident received Heparin and Normal Saline flushes before and after the antibiotics where administered and there should have been a dressing change completed every three days	F 280		

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F 280	Continued From page 3 while the Mediport was connected to the IV antibiotics. However, there was no documented evidence of these interventions on the care plan. The LPN stated she would have expected the nurse on duty, when the resident returned from the hospital, to have revised the care plan. An interview with the Assistant Director of Nursing (ADON), on 07/26/12 at 11:20 AM, reveled she would have expected the nurses to have accessed the care plan and updated the information to include dressing changes and flushes when the antibiotics and the Mediport were in use. An interview with the Director of Nursing (DON), on 07/26/12 at 11:50 AM, revealed the facility "maintains not accesses" the Mediport devices; however, the care plan should have been updated to include the IV antibiotics, flushes and dressing changes required. 2. A record review revealed Resident #2 was admitted on 04/21/10 with diagnoses to include Acquired Hemophilia, Renal Failure, Peripheral Vascular Disease, and Diabetes Mellitus. A review of the significant change MDS assessment, dated 07/03/12, revealed the resident had modified independence in cognitive thinking and needed the extensive assistance of two staff members for assistance with activities of daily living (ADLs). A review of the physician's order and nursing notes, dated 07/24/12, revealed an order for Normal Saline at 75 cc/hr due to elevated renal function testing and laboratory values.	F 280		

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F 280	Continued From page 4 An observation of Resident #2, on 07/25/12 at 3:15 PM, revealed the resident had an IV of Normal Saline, infusing per pump at 75 cubic centimeters (cc) per hour (hr), to the right forearm; however, a review of the care plan, dated 04/21/10, revealed the skin integrity care plan did not address the administration of IV fluids for Resident #2. An interview with the DON, on 07/26/12 at 3:53 PM, revealed she was not aware the skin integrity care plan had not been revised to include the addition of the IV and stated this should have been completed when the order was received.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy/procedure, and Lippincott Manual of Nursing Practice, Ninth Edition, IV Catheter Maintenance Guidelines, it was determined the facility failed to ensure services provided or arranged by the facility, met professional standards of quality for one resident (#1), in the selected sample of three residents, related to the failure to specify the need for Implanted Intravenous (IV) Catheter (Mediport) dressing changes to be administered every seven days, on the clinical record and to implement the dressing change. The facility failed to follow the Lippincott Manual of Nursing Practice, Ninth Edition, IV Catheter Maintenance Guidelines by	F 281	F281 It is the policy of NHC Madisonville to provide services that meet professional standards of quality. Resident # 1 no longer requires dressing changes to the Mediport IV access site as the site is no longer accessed. Overseen by the Director of Nursing an audit of all residents was conducted and no other residents were found to have Mediport IV access sites. Overseen by the Director of Nursing, the facility developed a Mediport IV access and un-accessed flow record that includes dressing change requirements. All licensed nursing staff received in-service training and education by the Director of Nursing on 07/26/12, 07/31/12, 08/03/12, and 08/06/12 pertaining to	

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F 281	Continued From page 5 not completing a dressing change to Resident #1's Mediport from 06/26/12 through 07/25/12 while being accessed with a Huber Needle for the use of IV antibiotics. Findings include: An interview with the Director of Nursing (DON), on 07/26/12 at 4:30 PM, revealed the facility did not have a specific policy for the nursing management of a Mediport device and stated the facility utilizes the Lippincott Manual, as a guide for the administration of nursing skills. A review of the Lippincott Manual of Nursing Practice, Ninth Edition, IV Catheter Maintenance Guidelines, on page #96, regarding implanted IV ports, revealed dressing changes, for these devices, should be completed every week, when accessed or when the Mediport is being utilized for the administration of Intravenous Fluids (IVFs) or antibiotics. The DON stated the Mediport did not require a dressing to the site or every shift flushing of the device when the site was not accessed for IVF. The only maintenance for the Mediport was a monthly visit to the hospital for flushing the device with Heparin and Normal Saline, to prevent clotting and infection. A record review revealed the Resident #1 was admitted on 04/14/05 with diagnoses to include Late Affect Cerebrovascular Accident (CVA,) Coronary Artery Disease (CAD), and a History of Cancer. Continued interview with the DON, on 07/26/12 at 4:30 PM, revealed Resident #1 had the Mediport "for years" and did not require a dressing to the site of the device when the site was not accessed for IVF.	F 281	obtaining orders for dressing changes and initiating the Mediport access flow records. Overseen and monitored by the Director of Nursing a Quality Assurance study of the center's compliance with dressing change requirements and flow records of Mediport IV access devices will be conducted monthly x 2 beginning in September 2012. The findings will be reported to the Quality Assurance committee. The monitoring and training will be continued by the DON or as directed by the Quality Assurance Committee.	8/7/2012

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F 281	Continued From page 6 A record review revealed the facility transferred Resident #1 to the hospital on 06/22/12 with Pneumonia and discharged back to the facility, on 06/26/12, with discharge instructions for IV antibiotics to continue the Mediport for an additional five days, to end on 07/01/12 at 1:00 AM. A review of the Medication Administration Records (MARs) and Treatment Administration Records (TARs) for June 2012 revealed, although the antibiotics were administered through the Mediport from 06/26/12 through 06/30/12, there was no documented evidence the facility had changed the dressing to the site of the device during this period of time. Review of the July 2012 MAR and TAR revealed, although the antibiotics were continued to be administered in July and discontinued, there was no documented evidence the facility completed dressing changes to the device site, per the facilities standard of practice and there was no documented evidence that the needle had been removed. A review of the significant change Minimum Data Set (MDS) assessment, dated 07/16/12, revealed the facility identified Resident #1 as moderately cognitively impaired and totally dependent on staff members for all care needs. On 07/17/12, the facility transferred Resident #1 to the hospital for the monthly flushing of the Mediport. An interview, on 07/25/12 at 11:08 AM, Hospital RN #1 revealed the resident presented with the same Mediport dressing and needle she had placed prior to his/her transfer back to the facility on 06/26/12. She stated on 07/17/12 she observed the same dressing she had applied to Resident #1's site which was dated 06/26/12 and had her initials written on the dressing.	F 281		

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F 281	Continued From page 7 An interview with Licensed Practical Nurse (LPN) #1, on 07/26/12 at 10:17 AM, revealed there should have been a dressing change done every week while the Mediport was connected to the IV antibiotics. LPN #1 stated she could find no evidence in Resident #1's MARs and TARs, nursing notes and IV Flow Records that the dressing to the Mediport had been changed, since returning from the hospital on 06/26/12 and stated she had not changed the dressing. An interview with the Assistant Director of Nursing (ADON), on 07/26/12 at 11:20 AM, reveled Resident #1 had returned from the local hospital, on 06/26/12, with orders to continue the administration of antibiotics to the Mediport until 07/02/12, when the round of antibiotics were completed; however, the Huber Needle and the Mediport Dressing were not removed and the dressing was not changed. The resident was sent to the cancer center, on 07/17/12, for the monthly flushing of the port, as this was a more intensive flush with a stronger Heparin solution, when the Huber Needle was discontinued and the old dressing removed. The ADON stated she would have expected the nurses to changed the dressings every week, while the port was in use. She was unable to access any information on the MARs and TARs or the nursing notes that would validate the dressing had been changed since the time it had been placed on the resident at the hospital on 06/26/12. An interview with the Director of Nursing (DON), on 07/26/12 at 11:50 AM, revealed the facility "maintains not accesses" the Mediport devices. However, the dressing changes should have	F 281		

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F 281	Continued From page 8 been documented and care planned and completed. An interview with LPN #1, on 07/26/12 at 10:17 AM, revealed the physician had ordered a second round of IV antibiotics on 07/19/12 and completed the antibiotics, on 07/25/12. The red dot was the result of the Huber Needle, that had been removed, after the last round of antibiotics, on 07/25/12, when the Mediport protective dressing and the needle was removed. An observation and skin assessment conducted on Resident #1, on 07/26/12 at 10:20 AM, revealed the resident resting quietly in bed with a small band-aid to the left upper chest area. The band-aid was removed to reveal a nickle-sized, raised area, where the skin covered the implanted Mediport device. A small red dot, near the center of the port, was the only redness noted to the site. An interview with the physician, on 07/26/12 at 1:20 PM, revealed the physician felt the dressing changes should have been completed.	F 281		