

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

PRINTED: 05/11/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R-C 04/26/2011 |
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| NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220 |
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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 |
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{F 000}

INITIAL COMMENTS

AMENDED

On 04/25-26/2011, an onsite revisit to the abbreviated survey (04/06/11) was conducted which determined Immediate Jeopardy (IJ) had been removed at F157, F281, F309, F490 and F520 on 04/18/11 as alleged in the Acceptable Allegation of Compliance (AOC) dated 04/23/11. While the IJ was removed at F157, F281, F309, F490 and F520, continued non-compliance remained as a S/S of "E". The facility's Quality Assessment and Assurance (QAA) Program had not completed the staff monitoring and analysis of information to prevent non-compliance from recurring.

The non-IJ deficiency, F241 and F282, cited during the abbreviated survey was not reviewed for compliance as the facility had not submitted a Plan of Correction (POC). Therefore, the deficiencies detailed on this Statement of deficiencies for the revisit of 04/25-26/11 include the F241 and F282 deficiencies identified on the abbreviated survey.

{F 000}

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.

To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

{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

{F 157}

F 157

It is the practice of this facility to 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

05/16/11
see addendum attachment for invoice date
M3

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James Beck Williams</i> | TITLE Admin | (X8) DATE 5/13/11 |
|---|----------------|----------------------|

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.

MAY 16 2011
Office of Inspector General
Northern Enforcement Branch

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{F 157}

Continued From page 1
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 legal representative or interested family member.

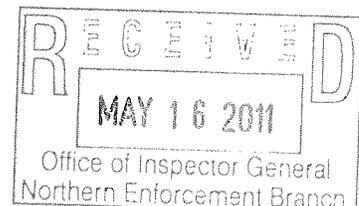
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, the Pain Practice Guide and Pain Care Plans, it was determined that the facility failed to evaluate the intensity, location, description of pain for three (3) of seven (7) sampled residents #3, #4 and #7. Furthermore, the facility's failure to complete pre and post pain score assessments for residents receiving PRN (as needed) medication prevented the facility from assessing the effectiveness of the medication, thus inhibited the facility from determining if the physician needed to be contacted for a change in treatment.

{F 157}

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 condition is 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).

It is the practice of this facility to 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.

It is the practice of this facility to record and periodically update the address and phone number of the resident's legal representative or interested family member.



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Continued From page 2
The Findings Include:

The Pain Practice Guide; Change in Condition section states if a change in patient condition occurs, the licensed nurse re-evaluates the intensity, location, type and history of pain and document findings in the progress notes of the patient's clinical record. Based upon this evaluation, the physician is notified to obtain orders if indicated. The patient's plan of care is reviewed and updated to reflect current care delivery needs.

Record review of pain care plans for Residents #3, #4, and #7 revealed the facility would evaluate pain characteristics: intensity, location and descriptor of pain.

Record review of Resident #3's MAR (medication administration record) for the month of April 2011 revealed since 04/21/11 through 04/25/11, there were eleven (11) opportunities for a pain evaluation to be completed by the facility, of the eleven (11) opportunities, the intensity was not utilized by the facility one (1) time (04/25/11). Review of the care plan dated 04/23/11 revealed pain medications were to be given as ordered by the physician with a note of effectiveness.

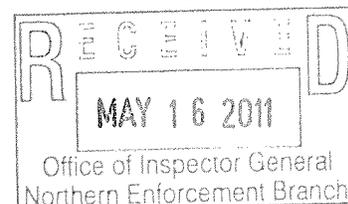
Record review of Resident #4's MAR for the month of April 2011 revealed since 04/18/11 through 04/25/11, there were fifteen (15) opportunities to conduct a pre and post pain score of the fifteen (15) opportunities, the intensity was not utilized by the facility six (6) times. Review of the care plan revised date of 04/16/11 revealed the same general interventions as Resident #3's.

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Residents #3 and 7 were discharged from the facility.

Resident #4 has been assessed by the Director of Care Delivery (DCD) of the unit and a current accurate pain evaluation identifying location of pain, type of pain, which pain scale to be used and additional descriptive information regarding each resident's pain and current treatment. Attending physician was notified as indicated for additional orders for pain control by the DCD. Residents #4s care plan was revised as needed by the DCD. Continued monitoring of effectiveness of pain regimen continues with pre- and post pain scores obtained and documented in the medication administration record (MAR) as indicated. The licensed nurse will follow the plan of care when documenting location, intensity and descriptor of pain when giving the as needed pain medication. Initial documentation was completed on



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Continued From page 3

Record review of Resident #7's MAR for the month of April 2011 revealed on two (2) occasions, it was documented the PRN medication was given; Baclofen 10mg for complaints of pain to left hip. On one (1) occasion it was documented the PRN medication was given; Baclofen 10mg for complaints of pain, eight (8) of ten (10). Review of the MAR revealed no pre or post score was ever documented, furthermore there was no evidence a pre and post scores were ordered for this medication. Review of the care plan dated 04/26/11 revealed the facility was to evaluate pain characteristics, i.e. intensity, location, and description of pain. Pain medication was to be administered per physician's orders. The physician was to be notified of any significant changes.

Interview with the Administrative Director of Nursing Services (ADNS) on 04/26/11 at 5:00pm revealed staff are to evaluate pain characteristics. Staff are trained to reassess if pain spikes and investigate. The ADNS stated that the charge nurse is to ensure reassessment is completed per Pain Practice Guide and the Director of Clinical Delivery (DCD) is responsible to ensure that PRN medications are given and physicians are called. The ADNS stated the charge nurse, Director of Clinical Delivery (DCD) was responsible to make sure nurses were completing pre and post pain scores. The ADNS further stated the only audit that she completed was to ensure the pain audit tool was completed by the DCD, she does not go through and check to see that each resident's pain score was recorded in the nurses notes, MAR and twenty-four hour report are accurately documented on the pain

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or before May 16, 2011 and continued monitoring is ongoing.

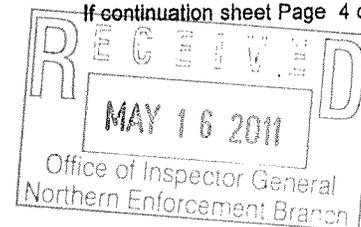
How will you identify other residents having the potential to be affected by the same deficient practice?

Current and newly admitted residents have the potential to be affected.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

In-service training for licensed nurses was completed by the Quality Improvement Specialist who is a Registered Nurse. Educational content consisted of the Pain Practice Guide, Federal Regulation 157 and utilization of the SBAR (Situation, Background, Assessment, and Request/Plan) tool. Education included:

- Initial Evaluation of pain upon admission
- Pain Rating Scales
- Pain Descriptions



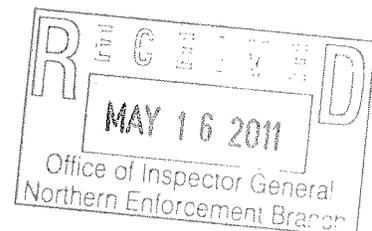
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| {F 157} | Continued From page 4 auditing tool by the DCD. The ADNS further stated there are just to many residents to complete this task. Interview with the Director of Clinical Services on 04/26/11 at 6:10pm revealed the nurses rely on residents requesting pain medication. Nurses are to evaluate pain characteristics which is stated in the care plan and interventions are to be documented for PRN pain medications regardless if the medication is a narcotic or not. Documentation of pain assessments still need improvement, they not being consistently completed at this time. | {F 157} | <ul style="list-style-type: none"> Types of Pain Initial and Comprehensive Care Plans Ongoing Pain Management Strategies Patient and Family Education Notification of Changes to Physician and Family <p>The Eagle Room Pain Process Tool was revised to monitor residents with identified pain to ensure the resident's pain goal is achieved and/or additional interventions are initiated. The areas that will be addressed are:</p> <ul style="list-style-type: none"> Pain occurrence evaluation Resident education to Pain Descriptors Physician and family notification Referrals Interventions Care Plan Development <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Resident's pain scores will be monitored by the Interdisciplinary</p> | |
| {F 241} SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to | {F 241} | | |

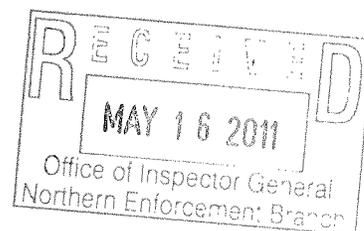


Team (IDT) utilizing the Pain Process tool, the Pain Management Tracking tool and the 24 hour Report to identify appropriate assessment, treatment, interventions and notification to the attending physician if pain is not relieved by current pain regimen. Team members on the IDT include the Licensed Nursing Home Administrator (LNHA), the Assistant Administrator, the Administrative Director of Nursing (ADNS), the Directors of Care Delivery (DCD), Social Workers, Dietitians, MDS Coordinator, Director of Rehabilitation (DOR), and the Activity Director.

The Directors of Care Delivery (DCD) will utilize the QAA Pain Audit tool to monitor those patients identified during the daily IDT meeting as having an increase in pain or a new onset of pain. The Audit will be completed beginning May 2, 2011 for 4 weeks unless deemed otherwise by the QAA Committee.

The Administrative Director of Nurses (ADNS) will validate the accuracy of audits completed by the DCD's by comparing audit results with patient record and completion of QAA Pain Audit tool. The Audit will be completed every week x4 unless deemed otherwise by the QAA Committee.

The QAA Eagle Room Pain Process Tool and the Pain Management Tracking Tool will be evaluated by the Quality Assurance and Assessment Committee Chairman for areas of non-compliance weekly until deemed corrected by the QAA Committee to determine if enhancements to the process are indicated. The QAA Committee members include the LNHA, the Assistant Administrator, the ADNS.

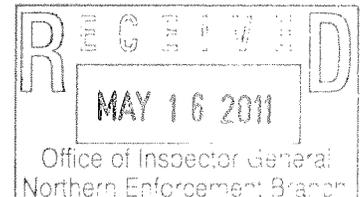


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DCD's, Social Workers, Dietitians, and the Human Resources Director. Areas of trending will include assessment, documentation, inter-department communication, physician and family notification, and treatment of patient pain beginning 4/15/11.

The Clinical Consultant will complete a compliance audit of both nursing and therapy processes utilizing the QAA Pain Audit Tool monthly x 6 months beginning 4/15/11. The Pain Audit Tool will monitor:

- Completion of Daily Pain score on MAR
- Completion of Pain Evaluation as needed
- Completion of SBAR as needed
- Notification of MD and Family
- Transcription of Pain medication orders
- Care plan completion/revision
- Documentation of pre- and post pain scores with PRN pain medications
- Documentation of location and descriptor of pain when PRN pain medications are given



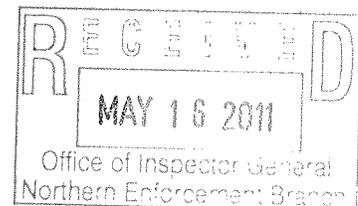
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| {F 241} | <p>Continued From page 5</p> <p>provide care for one (1) of nineteen (19) sampled residents (Resident #15) in a dignified manner. Resident #15 was observed in his room with a full facial beard, white flakey substances throughout hair, and the back of hair was knotted together. The findings include:</p> <p>Observation of Resident #15 on 03/15/11 and 03/16/11 during an abbreviated complaint survey revealed Resident #15 lying in bed with a full beard, white flakey substance throughout hair and the back of his/her hair knotted together. Resident #15 was assessed on the admission minimum data set assessment (MDS) dated 02/24/11, with a diagnosis of Morbid Obesity, HTN (hypertension), Depression, Atrial Fibrillation, and Gastroesophageal Reflux Disease (GERD). Further assessment of Resident #15's MDS (section G) for bathing revealed total dependence and extensive assistance from staff.</p> <p>Interview on 03/16/11 at 7:50 am with Resident #15 revealed the bath consisted of washing his/her face, underarms and front peri-area. The resident also stated no comb or brush had ever been offered during grooming. Resident #15 stated when he/she has refused care, it was to mean not now. Resident #15 further stated no staff made a second attempt to offer personal care.</p> <p>Interview on 03/16/11 at 3:30 pm with CNA #3 revealed the CNA cared for Resident #15 since admission and Resident #15 required two person assist and was totally dependent of staff for personal care. CNA #3 further stated they were trained on personal care, and that a bed bath required bathing the entire body. The CNA further revealed Resident #15 is so large and when no one is available to assist, the only care given is</p> | {F 241} | <p>F 241</p> <p>It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #15 has been discharged from the facility.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice?</p> <p>Current and newly admitted residents have the potential to be affected.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> | 5/16/11 |



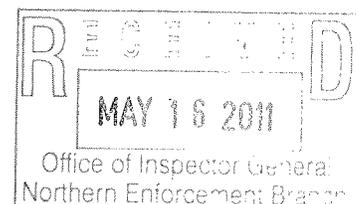
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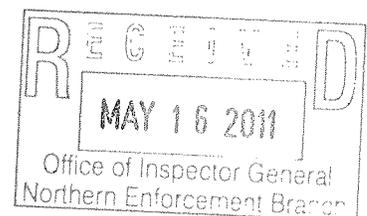
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| {F 241} | Continued From page 6 washing underarms and the front peri-area. CNA #3 stated he never offered Resident #15 a comb or hair brush. CNA #3 also stated not giving complete hygiene/bathing care would make a resident feel bad. Interview on 03/16/11 at 3:00pm with the Director of Clinical Division (DCD) on the 100 Unit revealed that CNA's are trained in personal care. A resident that is totally dependent for personal care should have their entire body bathed, hair combed, and teeth brushed. The DCD further stated if a resident refuses personal care, the CNA should notify the nurse, and then a second attempt should be offered by the nurse. If the resident still refuses, the CNA and the nurse must initial and mark the skin worksheet as refused. The DCD further stated the nurse should document in the nursing notes regarding the personal care refusal. The DCD stated she was ultimately responsible for the care given to the residents. The DCD also stated that she attempts to observe residents every day; however, Resident #15 had not been assessed lately. The DCD stated after her assessment of Resident #15, the quality of care was not good and placed the resident at increased risk for skin breakdown. Interview on 03/16/11 at 3:00pm with the Certified Occupational Therapy Assistant (COTA) revealed Resident #15's weight causes limited endurance. The COTA stated he noticed his/her beard was thick and had not always been well kept. The COTA further stated he never communicated to the nursing staff Resident #15's need for personal hygiene. COTA further stated by not reporting Resident #15's poor hygiene and the fact that Resident #15 was obese, the risk for skin breakdown was increased. | {F 241} | Nursing Assistants and Licensed Nurses will be in-serviced on the utilization of the Skin Worksheet, AM and HS Care Guidelines, and Bathing Guidelines by the Quality Improvement Specialist on or before May 16, 2011. The Skin Worksheets will be completed by the Nursing Assistants at least two times a week with the resident's bath (shower, tub, bed). Results will be submitted to the licensed nurse upon completion for review and follow-up as needed. During the daily IDT meeting the Skin Worksheets will be compared to the established shower schedule to ensure bathing was completed. How does the facility plan to monitor its performance to ensure that solutions are sustained? The ADNS or the DCD's of each unit will, through visual observation and interviews with patients, monitor completion of the Skin Worksheet and completion of ADLS utilizing the QAA Shower Audit Tool weekly x 4 weeks. | |
| {F 281} | 483.20(k)(3)(i) SERVICES PROVIDED MEET | {F 281} | | |



The QAA Shower Audit Tool will be evaluated by the Quality Assurance and Assessment Committee Members for areas of non-compliance weekly until deemed corrected by the QAA Committee to determine if enhancements to the process are indicated. Areas of trending will include completion of the resident's bathing as well as any indication of skin alteration beginning May 9, 2011.



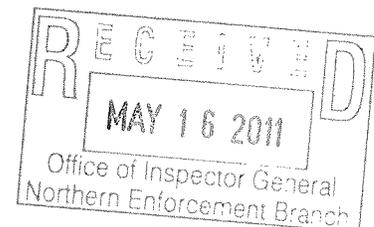
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| {F 281} SS=E | <p>Continued From page 7</p> <p>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 interview and record review it was determined that the facility failed to ensure the nursing staff met professional standards of quality of care for four (4) of seven (7) sampled residents. The facility failed to ensure the Director's of Clinical Delivery (DCD's) completed the Pain Management Tool and Pain Audit Tool's thoroughly to depict an accurate account of Resident #2's pain score for a twenty-four (24) hour period. The facility failed to ensure the nursing staff completed pre and post pain scores daily for Residents #3, #4 and #7.</p> <p>The findings include:</p> <p>Review of the Pain Management Tool revealed the directions were to review the twenty-four (24) report/change in condition report, medication administration record or other sources documented to identify patients with pain. Document the highest pain score observed or reported and the related post-treatment score each day. Patients with a score of four (4) to seven (7) twice in a seven day period or who had one score of eight, nine or ten are reviewed during the Eagle Room process and the findings submitted to the QAA committee for analysis of pain management interventions and updates to each patient plan of care.</p> | {F 281} | <p>F 281</p> <p>It is the practice of the facility to provide or arrange services to meet professional standards of quality.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents #2, #3, and #7 have been discharged from the facility.</p> <p>Resident #4 was assessed by the Director of Care Delivery (DCD) of the unit and a current accurate pain evaluation identifying location of pain, type of pain, which pain scale to be used and additional descriptive information regarding each resident's pain and current treatment. Attending physician was notified as indicated for review and adjustment of treatment. Resident #4 care plan were revised as needed. Continued monitoring of effectiveness of pain regimen continues with pre- and post pain scores obtained and documented in the medication administration record (MAR) as indicated. The</p> | 5/16/11 |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R-C 04/26/2011 |
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{F 281}

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1. Record review of Resident #2's Medication Administration Record (MAR) dated 04/19/11 revealed Tylenol 650mg suppository was given at 1:30am for complaints of pain; bladder spasms. No pre or post scores were documented on the MAR. Record review of the Pain Audit Tool utilized by the Director of Clinical Delivery (DCD) #1 revealed that pain scores were obtained on 04/19/11 for Resident #2. Record review of the Pain Management tool dated 04/19/11 revealed Resident #2 highest score of pain, for the day was a seven (7) and lowest score of pain was a zero (0). Record review of the SBAR dated 04/19/11 revealed Resident #2 rated pain, on a scale of zero (0) to ten (10) (zero meaning no pain and ten meaning the greatest amount of pain), as a ten (10).

Interview with the DCD #1 on 04/26/11 at 10:35am revealed she audits the PRN pain scores, therapy notes off the twenty-four (24) hour report, nurses notes, SBAR and if the MD and the family were called. DCD #1 further stated the pain score of ten (10) on the SBAR was missed because there new system indicates that they identify if the SBAR was completed, it does not indicate to evaluate if a score was given on the SBAR. DCD #1 also stated that she can see that the SBAR scores need to be incorporated into the process.

2. Record review of Resident #7's PRN pain medication orders revealed Baclofen 10mg by mouth four times a day as needed for spasms. Review of the MAR dated 04/11 revealed Resident #7 received three (3) doses of Baclofen on 04/23/11 at 11:45am and 5:00pm and on 04/25/11 at 8:00am. On two (2) occasions it was

{F 281}

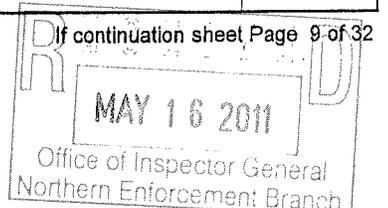
licensed nurse will follow the plan of care when documenting location, intensity and descriptor of pain when giving the as needed pain medication. An SBAR will be completed as indicated if there is a Change in condition, prior to contacting the physician. Initial documentation was completed on or before May 2, 2011 and continued monitoring is ongoing.

How will you identify other residents having the potential to be affected by the same deficient practice?

Current and newly admitted residents have the potential to be affected.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

In-service training for licensed nurses was completed on or before 4/17/11 by the Quality Improvement Specialist who is a Registered Nurse. Educational



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{F 281}

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documented the PRN medication was given; Baclofen 10mg for complaints of pain to left hip. On one (1) occasion it was documented the PRN medication was given; Baclofen 10mg for complaints of pain, eight (8) of ten (10). Review of the MAR revealed no pre or post scores were given as it relates to the pre and post scores not being ordered for this medication.

3. Record review of Resident #4's PRN pain medication orders revealed Morphine Sulfate (MS) Liquid 10mg/5ml solution to be given 2.5ml every four (4) hours PRN pain. The facility was to utilize pre and post pain scores for the MS liquid solution orders. Record review of Resident #4's MAR dated 4/11 revealed since 04/18/11 through 04/25/11, there were fifteen (15) opportunities to conduct a pre and post pain score. There was no documented evidence of intensity assessed by the facility six (6) times.

4. Record review of Resident #3's admitting orders revealed Tylenol ES (extra strength) one (1) tablet every four (4) hours as needed (PRN) mild pain and Tylenol ES two (2) tablets every four (4) hours PRN moderate pain. The facility was to utilize pre and post pain scores for Tylenol ES one tablet and Tylenol ES two tablet orders. Record review of Resident #3's MAR dated 4/11 revealed since 04/21/11 through 04/25/11, there were eleven (11) opportunities for a pain evaluation to be completed by the facility, of the eleven (11) opportunities, there was no documented evidence the intensity was assessed by the facility one (1) time.

Interview with the Director of Clinical Services on 04/25/11 at 10:30am revealed pre and post

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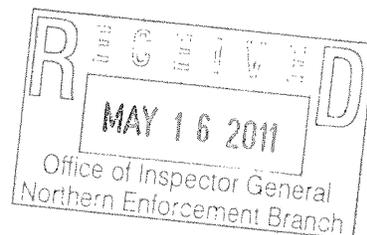
content consisted of the Pain Practice Guide to include:

- Initial Evaluation of pain upon admission
- Pain Rating Scales
- Pain Descriptions
- Types of Pain
- Initial and Comprehensive Care Plans
- Ongoing Pain Management Strategies
- Patient and Family Education
- Utilization of the SBAR tools
- Notification of Changes to Physician and Family

Specific training was completed with the licensed nurses on completion of the Pain Care Plan to include:

- Focus of the problem
- Goal of the Patients Pain
- Specific Interventions related to addressing pain

The Eagle Room Pain Process Tool was revised to monitor residents with identified pain to ensure the resident's pain goal is achieved and/or additional interventions are initiated. The areas that will be addressed are:



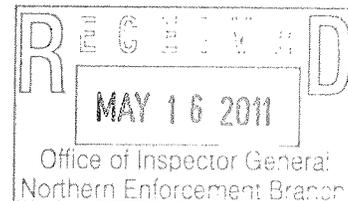
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| {F 281} | <p>Continued From page 10</p> <p>scores, descriptor and location need to be added to the audit tool so the audit will produce positive results. Furthermore on 04/26/11 at 6:00pm the Director of Clinical Services revealed that it was there policy to complete pre and post pain scores on all PRN pain medication.</p> <p>Interview with the DCD on 04/26/11 at 2:15pm, revealed information about the intensity of pain should be documented on the MAR.</p> <p>Interview with the Administrative Director of Services (ADNS), on 04/26/11 at 5:00pm, revealed the DCD's are responsible to make sure nurses are completing pre and post pain assessments of residents. The ADNS further stated it is her expectation that the system is followed, we assess pain, call the Physician and call the family of the residents.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/23/11. The state agency verified Immediately Jeopardy was removed during the onsite survey of 04/25-26, 2011, which lowered the scope and severity to a "E" at F281 while the facility's Quality Assurance monitors the effectiveness of audit tools for pain scores to identify appropriate assessment and treatment are in place as well as pain care plans.</p> | {F 281} | <ul style="list-style-type: none"> • Pain occurrence evaluation • Resident education to Pain Descriptors • Completion of SBAR when indicated • Physician and family notification • Referrals • Interventions • Care Plan Development <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Resident's pain scores will be monitored by the IDT utilizing the Pain Process tool, the Pain Management Tracking tool and the 24 hour Report, to identify appropriate assessment, treatment, interventions and notification to the attending physician if pain is not relieved.</p> <p>The Directors of Care Delivery (DCD) will utilize the QAA Pain Audit tool to monitor those patients identified during the daily IDT meeting as having an increase in pain or a new onset of pain. The Audit will be</p> | |
| {F 282} | <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>SS=D</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> | {F 282} | | |



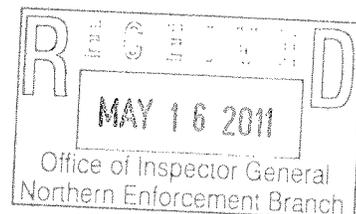
completed weekly x4, unless deemed otherwise by the QAA Committee.

The Administrative Director of Nurses (ADNS) will validate the accuracy of audits completed by the DCD's by comparing audit results with patient record and completion of QAA Pain Audit tool. The Audit will be completed weekly x4 unless deemed otherwise by the QAA Committee.

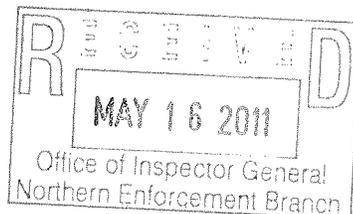
The QAA Eagle Room Pain Process Tool and the Pain Management Tracking Tool will be evaluated by the Quality Assurance and Assessment Committee Chairman for areas of non-compliance weekly until deemed corrected by the QAA Committee to determine if enhancements to the process are indicated. The QAA Committee members include the LNHA, the Assistant Administrator, the ADNS, DCD's, Social Workers, Dietitians, and the Human Resources Director. Areas of trending will include assessment, documentation, inter-department communication, physician and family notification, and treatment of patient pain beginning 4/15/11.

The Clinical Consultant will complete a compliance audit of both nursing and therapy processes utilizing the QAA Pain Audit Tool monthly x 6 months beginning 4/15/11. The Pain Audit Tool will monitor:

- Completion of Daily Pain score on MAR
- Completion of Pain Evaluation as needed
- Completion of SBAR as needed
- Notification of MD and Family
- Transcription of Pain medication orders
- Care plan completion/revision



- Documentation of pre- and post pain scores with PRN pain medications
- Documentation of location and descriptor of pain when PRN pain medications are given



11B

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{F 282}

Continued From page 11
This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined the facility failed to implement a care plan related to pain, note the effectiveness of the as needed (PRN) medication and evaluate the characteristics of the PRN medication for four (4) of nineteen (19) sampled residents, Resident #4, #5, #7 and #9. Resident's #4, #5 and #7's plan of care for pain revealed to give PRN medication for breakthrough pain per physician order and note the effectiveness and evaluate pain characteristics. Resident #9's plan of care for pain revealed to give PRN medication for breakthrough pain per physician order to note the effectiveness.

The findings include:

The facility had no written policy on pain or pain assessment, however, a Pain Process Flowchart was utilized for the assessment, planning, implementation and evaluation of pain for residents. The flow chart states for those residents with a history of pain, residents will be screened for pain daily and documented on. The flow chart does not state who is responsible for the screening assessment, documentation or follow up procedures.

1. Record review of Resident #4 revealed an admission date of 03/02/11 with a diagnosis of morbid obesity, bladder spasms, restless leg syndrome, end stage renal disease and VRE (Vancomycin Resistant Enterococcus) wound infection. The Minimum Data Set (MDS) dated 3/15/11 revealed a Brief Interview for Mental Status (BIMS) score was documented as a

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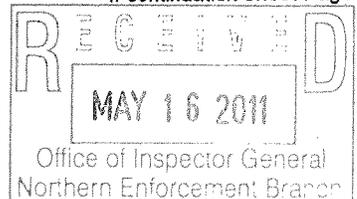
F 282
It is the practice of the facility to provide or arrange for services that are provided by qualified persons in accordance with each resident's written plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident #7 has been discharged from the facility.

Residents #4, #5 and #9 were assessed by the Director of Care Delivery (DCD) of the unit and a current accurate pain evaluation identifying location of pain, type of pain, which pain scale to be used and additional descriptive information regarding each resident's pain and current treatment. Attending physicians were notified as indicated for additional orders for pain control by the DCD. Residents #4, #5 and #9 care plans were revised as needed by the DCD's. Continued monitoring of effectiveness of pain regimen continues with pre- and post pain

5/16/11



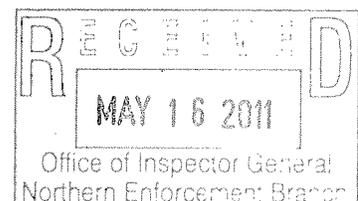
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| {F 282} | <p>Continued From page 12</p> <p>fourteen (14) which identifies this resident as being cognitive (interviewable). Resident #4's admitting orders revealed Lortab 5/325 mg was to be given every 4 hours as needed for pain, including Lortab pre and post pain scores. Interview with Resident #4 on 03/31/11 at 7:30am revealed he/she was having bladder spasms through the night of 03/30/11 and received PRN Lortab for pain. Review of the MAR and nursing notes revealed no pain assessment was evaluated or documented.</p> <p>Record review of Resident #4's MAR revealed since admission on 03/02/11 through 03/31/11, there were seventy-three (73) opportunities for a pain assessment to be completed by the facility, of the seventy-three (73) opportunities, the pain assessment score was not utilized by the facility sixty-one (61) times.</p> <p>Review of Resident #4's care plan revealed nursing should assess for the resident's pain intensity, location, precipitating/relieving factors of pain; however, review of the nurses' notes for this resident and the pain medication administration revealed no documentation the nursing staff had assessed the resident's pain sixty-one (61) times from 03/02/11 through 03/31/11. Interview, on 04/11/11 at 10:35am, with the ADNS confirmed that the pain assessment for Resident #4 was not completed.</p> <p>2. Record review of Resident #7 revealed an admission date of 03/04/11 with multiple diagnoses which included breast cancer, with metastasis to bone, and chronic pain. Resident #7's admitting orders revealed MS Contin 15 mg, give one tablet by mouth twice a day. Review of</p> | {F 282} | <p>scores obtained and documented in the medication administration record (MAR) as indicated. The licensed nurse will follow the plan of care when documenting location, intensity and descriptor of pain when giving the as needed pain medication. Initial documentation was completed on or before May 2, 2011 and continued monitoring is ongoing.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice?</p> <p>Current and newly admitted resident have the potential to be affected.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>In-service training for licensed nurses was completed on or before 4/17/11 by the Quality Improvement Specialist who is a Registered Nurse. Educational content consisted of the Pain</p> | |



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the Roster Matrix revealed Resident #7 was not marked to have a cognitive impairment. Review of the morning pain assessment revealed five (5) of the twenty-seven (27) opportunities to complete the morning assessment was not completed by the nursing department. Record Review of Resident #7's MAR revealed since admission on 03/04/11 through 03/31/11, there were twenty-six (26) opportunities for a pain assessment to be completed by the facility, of the twenty-six (26) opportunities, the pain assessment score was not utilized by the facility twenty (20) times. Observation of Resident #7 on 04/06/11 at 8:15am revealed facial grimacing when the resident finished his/her therapy. Interview with Resident #7 on 04/06/11 at 8:15am revealed he/she had not received pain medication that morning. Interview with Nurse Manager RN #5 on 04/06/11 at 11:05am revealed the pain characteristics: intensity, location, precipitating and relieving factors were to be charted in the nursing notes.

Review of Resident #7's care plan revealed nursing staff was to assess the resident's pain intensity, location, precipitating/relieving factors of pain; however, review of the nursing notes and MAR since admission on 03/04/11 revealed no documented entries of such assessments despite having administered pain medication twenty (20) times.

3. Record review of Resident #9 revealed an admission date of 03/11/11 with a diagnosis of morbid obesity, kidney disease and chronic obstructive pulmonary disease. Review of the MDS dated 03/18/11 revealed Resident #9 had a BIMS score of fifteen (15), which means this

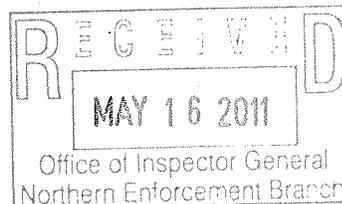
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Practice Guide to include:

- Initial Evaluation of pain upon admission
- Pain Rating Scales
- Pain Descriptions
- Types of Pain
- Initial and Comprehensive Care Plans
- Ongoing Pain Management Strategies
- Patient and Family Education
- Utilization of the SBAR tool as indicated
- Notification of Changes to Physician and Family

Amendments to the QAA evaluation process include the following:

The IDT meeting agenda was revised on 4/2/11 by the LNHA to require in person attendance of the DOR or a therapist assigned to be the lead therapist in her absence to communicate any pain that had been previously noted in therapy to the nursing department for follow up as well as notification at the time of the resident's complaint of pain to the licensed nurse.



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resident was not cognitively impaired. Resident #9's admitting orders revealed Morphine Sulfate 2.5 ml (5 mg) orally every 4 hours PRN, including a pre and post pain score with Morphine Sulfate administration.

Record review of the care plan for Resident #9 stated to note the effectiveness of the PRN pain medication and to notify the physician if pain frequency/intensity was worsening or if current analgesic regimen had become ineffective. Record review of the MAR on 04/02/11 revealed Resident #9 received morphine 2.5 ml two (2) times. Review of the MAR on 04/03/11 revealed Resident #9 received morphine 2.5 ml, five (5) times. Review of the MAR on 04/04/11 revealed Resident #9 received morphine 2.5 ml, five (5) times.

Record review of the MAR for Resident #9 revealed PRN pain medication had been administered without noting the effectiveness, fifteen (15) out of fifteen (15) times. The current MAR and nurses notes for April 1 to April 6, 2011, revealed fifteen (15) opportunities for pain assessment, of the fifteen (15) opportunities, the pain score was not utilized eleven (11) times.

4. Record review of Resident #5 revealed an admission date of 03/20/11 with a diagnosis of multiple sclerosis, degenerative joint disease, osteoporosis and spasms. Resident #5's admitting orders revealed Morphine 60 mg every eight (8) hours, Norco 7.5/325 mg take one (1) tablet every 4 hours as needed for pain, including a pre and post pain score with Norco administration and Tylenol 650 mg taken rectally every 6 hours as needed for pain, including a pre

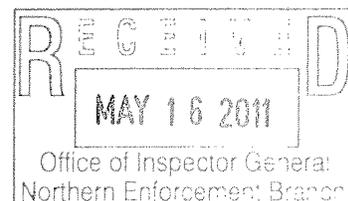
{F 282}

The Eagle Room Pain Process Tool was revised to monitor residents with identified pain to ensure the resident's pain goal is achieved and/or additional interventions are initiated. The areas that will be addressed are:

- Pain occurrence evaluation
- Resident education to Pain Descriptors
- Physician and family notification
- Referrals
- Interventions
- Care Plan Development

How does the facility plan to monitor its performance to ensure that solutions are sustained?

Resident's pain scores will be monitored by the IDT utilizing the Pain Process tool, the Pain Management Tracking tool and the 24 hour Report beginning 4/2/11 to identify appropriate assessment, treatment, interventions and notification to the attending physician if pain is not relieved.



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| NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220 |
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{F 282}

Continued From page 15 and post pain score with Tylenol administration.

Record Review for Resident #5 MAR from March 20 through March 30, 2011, revealed thirty-five (35) opportunities for a pain score assessment to be completed, of the thirty-five (35) opportunities, the pain assessment score was not utilized by the facility twenty-eight (28) times.

Upon review of 03/2011 MAR for Resident #5, LPN #4 acknowledged more entries of the pre and post scores should of been documented. Interview with LPN #4 on 04/01/11 at 9:40am revealed she felt the biggest problem with documentation compliance, was the fact that there was so little room to document the scale for the time the medication was given. LPN #4 also stated that the pre and post scores were important to the physician and believes the staff would be more likely to comply with documentation if room was provided on the pre and post section of the MAR.

Interview on 03/30/11 at 11:40am with Licensed Practical Nurse (LPN) #3 revealed nurses were to place the pain score on the pain assessment located on the MAR. Post medication administration scores was to be assessed within two (2) hours of administration.

Interview on 03/30/11 at 11:50am with Registered Nurse (RN) #2 revealed during the medication pass the residents were asked their pain score.

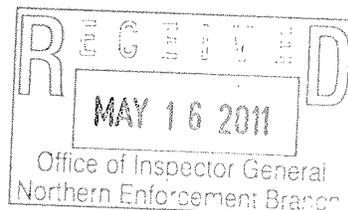
Interview on 03/30/11 at 2:00pm with RN #3 revealed a pain assessment was done with each resident complaint of pain.

{F 282}

The Directors of Care Delivery (DCD) will utilize the QAA Pain Audit tool to monitor those patients identified during the daily IDT meeting as having an increase in pain or a new onset of pain. The Audit will be completed beginning May 2, 2011 for 4 weeks unless deemed otherwise by the QAA Committee.

The Administrative Director of Nurses (ADNS) will validate the accuracy of audits completed by the DCD's by comparing audit results with patient record and completion of QAA Pain Audit tool. The Audit will be completed beginning May 2, 2011 for 4 weeks unless deemed otherwise by the QAA Committee.

The QAA Eagle Room Pain Process Tool and the Pain Management Tracking Tool will be evaluated by the Quality Assurance and Assessment Committee Chairman for areas of non-compliance weekly until deemed corrected by the QAA Committee to determine if enhancements to the process are indicated. The QAA Committee members include the LNHA, the Assistant Administrator, the ADNS,



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{F 282} Continued From page 16
Interview on 03/30/11 at 10:35am with the Administrative Director of Nursing (ADON) revealed a pain assessments were to be completed if a resident complained of pain.

Interview on 03/31/11 at 7:30am with RN #4 revealed if a resident complains of pain, it was charted on the MAR.

Interview on 04/06/11 at 2:00pm with the Nurse Manager for the 100 Hall revealed documentation for pain characteristics "should be in the nurse's notes". It was further revealed documentation for the evaluation of pain "should be in the nurse's notes".

Interview on 04/06/11 at 2:00pm with LPN #4 revealed pain assessment documentation and pain evaluation documentation "should be in the nurse's notes".

{F 309} 483.25 PROVIDE CARE/SERVICES FOR SS=E HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

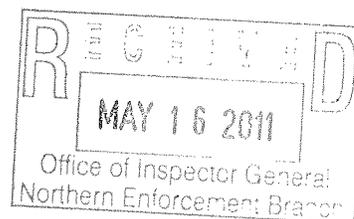
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, pain process guide and pain management tool, it was determined the facility failed to effectively maintain the highest practicable physical

{F 282} DCD's, Social Workers, Dietitians, and the Human Resources Director. Areas of trending will include assessment, documentation, inter-department communication, physician and family notification, and treatment of patient pain beginning 4/15/11.

The Clinical Consultant will complete a compliance audit of both nursing and therapy processes utilizing the QAA Pain Audit Tool monthly x 6 months beginning 4/15/11. The Pain Audit Tool will monitor:

- Completion of Daily Pain score on MAR
- Completion of Pain Evaluation as needed
- Completion of SBAR as needed
- Notification of MD and Family
- Transcription of Pain medication orders
- Care plan completion/revision
- Documentation of pre- and post pain scores with PRN pain medications
- Documentation of location and descriptor of pain when PRN pain medications are given

{F 309}



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{F 309}

Continued From page 17
well-being for four (4) of seven (7) sampled residents (Residents #2, #3, #4 and #7). The facility failed to provide a quality assessment which depicted an accurate account of Resident #2 and #7's pain. The facility failed to develop and implement an effective system to ensure that the nursing staff assessed and evaluated the characteristics of; intensity, location, and descriptors of pain for Residents #3 and #4.

The findings include:

Review of the Pain Process Guide revealed patients are evaluated daily for evidence of pain. A pain evaluation is also completed before and after routine and PRN pain medication administration. The patients pain scale score is recorded on the Medication Administration Record (MAR).

Review of the Pain Management Tool revealed the directions were to review the twenty-four (24) report/change in condition report, medication administration record or other sources documented to identify patients with pain. Document the highest pain score observed or reported and the related post-treatment score each day. Patients with a score of four (4) to seven (7) twice in a seven day period or who had one score of eight, nine or ten are reviewed during the Eagle Room process and the findings submitted to the QAA committee for analysis of pain management interventions and updates to each patient plan of care

1. Record review of Resident #2's medical record revealed an admission date of 03/20/11 with a diagnosis of multiple sclerosis, osteoporosis,

{F 309}

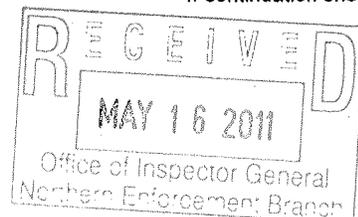
F 309
It is the practice of the facility to ensure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident #2, #3 and #7 have been discharged from the facility.

Resident #4 has been assessed by the of the unit and a current accurate pain evaluation identifying location of pain, type of pain, which pain scale to be used and additional descriptive information regarding each resident's pain and current treatment. Attending physician was notified as indicated for review and adjustment of treatment. Resident #4 care plan was revised as needed. Continued monitoring of effectiveness of pain regimen

5/16/11



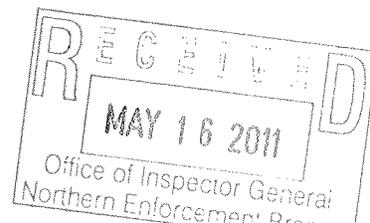
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| {F 309} | <p>Continued From page 18</p> <p>degenerative joint disease and chronic back pain. Resident #2's as needed (PRN) medication orders (dated 03/20/11) revealed Tylenol 650mg with directions to insert two (2) suppositories rectally every six (6) hours for mild pain with the utilization of a pain score before and after giving pain medication.</p> <p>Record review of the Medication Administration Record (MAR) dated 04/19/11 revealed Tylenol 650mg suppository was given at 1:30am for complaints of pain; bladder spasms. No pre or post scores were documented on the MAR. Record review of the Pain Audit Tool utilized by the Director of Clinical Delivery (DCD) #1 revealed that pain scores were obtained on 04/19/11 for Resident #2. Record review of the Pain Management tool dated 04/19/11 revealed Resident #2's highest score of pain for the day was a seven (7) and lowest score of pain was a zero (0). Record review of the SBAR dated 04/19/11 revealed Resident #2 rated pain, on a scale of zero (0) to ten (10) (zero meaning no pain and ten meaning the greatest amount of pain), as a ten (10).</p> <p>Interview with the DCD #1, on 04/26/11 at 10:35am, revealed she audits the PRN pain scores, therapy notes off the twenty-four (24) hour report, nurses notes, SBAR (and if the MD and the family were called. DCD #1 further stated the pain score of ten (10) on the SBAR was missed because there new system indicates that they identify if the SBAR was completed, it does not indicate to evaluate if a score was given on the SBAR. DCD #1 also stated that she can see that the SBAR scores need to be incorporated into the process.</p> | {F 309} | <p>continues with pre- and post pain scores obtained and documented in the medication administration record (MAR) as indicated. The licensed nurse will follow the plan of care when documenting location, intensity and descriptor of pain when giving the as needed pain medication. An SBAR will be completed as indicated if there is a Change in condition, prior to contacting the physician. Initial documentation was completed on or before May 2, 2011 and continued monitoring is ongoing.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice?</p> <p>Current and newly admitted residents have the potential to be affected.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> | |



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{F 309}

Continued From page 19

2. Record review of Resident #7's medical record revealed an admission date of 04/26/11 with a diagnosis of liposarcoma of the left thigh, osteoarthritis, left leg muscle repair with flap. Resident #7's PRN pain medication orders (dated 04/22/11) revealed Baclofen 10mg by mouth four times a day as needed for spasms.

Review of the MAR dated 04/11 revealed Resident #7 received three (3) doses of Baclofen on 04/23/11 at 11:45am and 5:00pm and on 04/25/11 at 8:00am. On two (2) occasions it was documented the PRN medication was given; Baclofen 10mg for complaints of pain to left hip. On one (1) occasion it was documented the PRN medication was given; Baclofen 10mg for complaints of pain with pain score of eight (8) of ten (10). Review of the MAR revealed no pre or post pain scores were documented.

3. Record review of Resident #4's medical record revealed an admission date of 03/11/11 with a diagnosis of morbid obesity, kidney disease and chronic airway obstruction. Resident #4's PRN pain medication orders revealed Morphine Sulfate (MS) Liquid 10mg/5ml solution to be given 2.5ml every four (4) hours PRN pain. The facility was to utilize pre and post pain scores for the MS liquid solution orders.

Record review of Resident #4's care plan created on 03/11/11, with a focus on pain revealed pain would be evaluated for characteristics of intensity, location and descriptors.

Record review of Resident #4's MAR dated 4/11

{F 309}

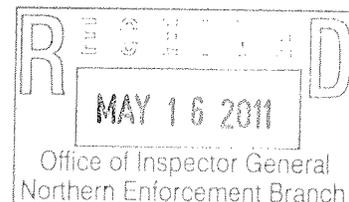
In-service training for licensed nurses was completed on or before 4/17/11 by the Quality Improvement Specialist who is a Registered Nurse. Educational content consisted of the Pain Practice Guide to include:

- Initial Evaluation of pain upon admission
- Pain Rating Scales
- Pain Descriptions
- Types of Pain
- Initial and Comprehensive Care Plans
- Ongoing Pain Management Strategies
- Patient and Family Education
- Utilization of the SBAR tools
- Notification of Changes to Physician and Family

Specific training was completed with the licensed nurses on completion of the Pain Care Plan to include:

- Focus of the problem
- Goal of the Patients Pain
- Specific Interventions related to addressing pain

The Eagle Room Pain Process Tool was revised to monitor residents with identified pain to ensure the



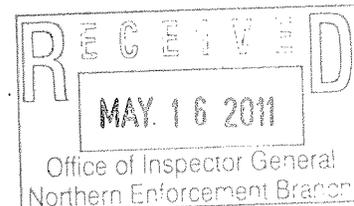
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| {F 309} | <p>Continued From page 20</p> <p>revealed since 04/18/11 through 04/25/11, there were fifteen (15) opportunities, the intensity was not utilized by the facility six (6) times, the location was not utilized by the facility five (5) times and the description of the pain was not utilized by the facility seven (7) times.</p> <p>4. Record review of Resident #3's medical record revealed an admission date of 04/04/11 with a diagnosis of low back pain, lumbar fusion and spinal stenosis. Resident #3's admitting orders revealed Tylenol ES (extra strength) one (1) tablet every four hours as needed (PRN) mild pain and Tylenol ES two (2) tablets every four (4) hours PRN moderate pain. The facility was to utilize pre and post pain scores for Tylenol ES one tablet and Tylenol ES two tablet orders.</p> <p>Record review of Resident #3's care plan created on 04/05/11 with a focus on pain revealed pain would be evaluated for characteristics of intensity, location and descriptors of pain.</p> <p>Record review of Resident #3's MAR dated 4/11 revealed since 04/21/11 through 04/25/11, there were eleven (11) opportunities for a pain evaluation to be completed by the facility, of the eleven (11) opportunities, the intensity was not utilized by the facility one (1) time, the location was not utilized by the facility five (5) times and the description of the pain was not utilized by the facility six (6) times.</p> <p>Interview with the Director of Clinical Services on 04/25/11 at 10:30am revealed pre and post pain scores, descriptor and location of pain need to be added to the audit tool so the audit will produce positive results. Furthermore, on 04/26/11 at</p> | {F 309} | <p>resident's pain goal is achieved and/or additional interventions are initiated. The areas that will be addressed are:</p> <ul style="list-style-type: none"> • Pain occurrence evaluation • Resident education to Pain Descriptors • Completion of SBAR when indicated • Physician and family notification • Referrals • Interventions • Care Plan Development <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Resident's pain scores will be monitored by the IDT utilizing the Pain Process tool, the Pain Management Tracking tool and the 24 hour Report, to identify appropriate assessment, treatment, interventions and notification to the attending physician if pain is not relieved.</p> <p>The Directors of Care Delivery (DCD) will utilize the QAA Pain Audit tool to monitor those patients identified</p> | |



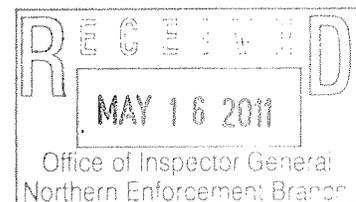
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| {F 309} | Continued From page 21 6:00pm, the Director of Clinical Services revealed it was facility policy to complete pre and post pain scores on all PRN pain medication. Interview with the DCD #3 on 04/26/11 at 2:15pm revealed information about the description of pain, the location of pain and the intensity of pain should be documented on the MAR. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/23/11. The state agency verified Immediately Jeopardy was removed during the onsite survey of 04/25-26, 2011, which lowered the scope and severity to a "E" at F309 while the facility's Quality Assurance monitors the effectiveness of pain score tools, pain process tools, and pain tracking audits. The resident's pain scores are to be monitored to determine if alternative interventions are indicated and the physician is to be notified of any changes. | {F 309} | during the daily IDT meeting as having an increase in pain or a new onset of pain. The Audit will be completed weekly x4, unless deemed otherwise by the QAA Committee. The Administrative Director of Nurses (ADNS) will validate the accuracy of audits completed by the DCD's by comparing audit results with patient record and completion of QAA Pain Audit tool. The Audit will be completed weekly x4 unless deemed otherwise by the QAA Committee. | |
| {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. | {F 441} | The QAA Eagle Room Pain Process Tool and the Pain Management Tracking Tool will be evaluated by the Quality Assurance and Assessment Committee Chairman for areas of non-compliance weekly until deemed corrected by the QAA Committee to determine if enhancements to the process are indicated. The QAA Committee members include the LNHA, the Assistant Administrator, the ADNS, DCD's, Social Workers, Dietitians, and the Human Resources Director. Areas of trending will include | |



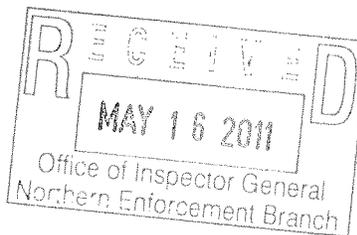
assessment, documentation, inter-department communication, physician and family notification, and treatment of patient pain beginning 4/15/11.

The Clinical Consultant will complete a compliance audit of both nursing and therapy processes utilizing the

QAA Pain Audit Tool monthly x 6 months beginning 4/15/11. The

Pain Audit Tool will monitor:

- Completion of Daily Pain score on MAR
- Completion of Pain Evaluation as needed
- Completion of SBAR as needed
- Notification of MD and Family
- Transcription of Pain medication orders
- Care plan completion/revision
- Documentation of pre- and post pain scores with PRN pain medications
- Documentation of location and descriptor of pain when PRN pain medications are given



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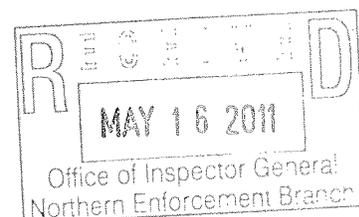
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| {F 441} | <p>Continued From page 22</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility 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 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, interview, Infection Control Guideline Book, and record review, it was determined the facility failed to maintain an infection control program to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection for six (6) of nineteen (19) sampled residents (Residents #2, 3, 11, 12, 13, 14).</p> <p>The findings include: The facility utilized an Infection Control Guideline Book for catheter care and it does not address</p> | {F 441} | <p>F 441</p> <p>It is the practice of the facility to establish and maintain an Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents #2, 3, and 14 have been discharged from the facility</p> <p>Residents #12 and 13's nebulizer masks will be stored per policy.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice?</p> <p>Current and newly admitted residents have the potential to be affected.</p> | <p>5/16/11</p> <p><i>see addendum attachment for Res #11</i> <i>mz</i></p> |



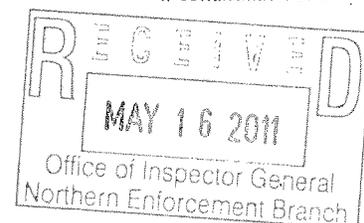
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| {F 441} | <p>Continued From page 23</p> <p>the positioning of the Foley catheter bag however, the Infection Control Guidelines state that for respiratory/oxygen administration a plastic bag should cover the oxygen cannula or mask, storage with label, date and resident name. The Nebulizer Mist Therapy guideline states to store dried nebulizer, t-piece, mouthpiece or mask in separate, labeled plastic bags and to clearly label administration sets for intravenous infusion administration with a date, time of change and nurses initials. The Infection Control Guideline Book further states intravenous tubing changes to be performed every seventy-two (72) hours.</p> <p>Observations on 03/30/11 at 9:10am, 03/31/11 at 7:30am and 04/01/11 at 7:05am revealed the Foley catheter bag for Resident #3 was on the floor by his/her bed.</p> <p>Observation on 03/30/11 at 9:00am revealed oxygen tubing was not dated for Residents #2, #12, #13 and #14.</p> <p>Observation on 03/30/11 at 9:00am revealed nebulizer masks were not covered or dated for Residents #2, #12 and #13.</p> <p>Observation on 03/30/11 at 9:15am of Resident #11's intravenous (IV) tubing revealed no date on two (2) separate medication solutions hanging in the room.</p> <p>Observation on 03/30/11 at 9:05am revealed a urinal with urine in it, on the night stand in one resident room and in another resident room a urinal on an overbed table sitting next to food and beverage.</p> | {F 441} | <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>In-service training for licensed nurses and certified nursing assistants will be completed on or before May 16, 2011 by the Quality Improvement Specialist who is a Registered Nurse. Education included:</p> <ul style="list-style-type: none"> • Proper storage and labeling of IV tubing, Oxygen tubing, Nebulizers, Foley Catheter tubing and bags • Storage of urinals <p>Additional in-servicing training for Administrative, Therapy, Housekeeping/Laundry, and Dietary staff will be completed on or before May 16, 2011 by the Quality Improvement Specialist who is a Registered Nurse. Education includes:</p> <ul style="list-style-type: none"> • Identification of proper storage and labeling of IV tubing, Oxygen tubing, Nebulizers, Foley Catheter tubing and bags • Storage of urinals | |



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{F 441} Continued From page 24

Interview on 04/01/11 at 2:30pm with the Administrative Director of Nursing (ADON) revealed Foley catheter bags are to be positioned below the level of the bladder, but not on the floor. It was further revealed oxygen tubing is to be changed weekly, labeled, and stored in a plastic bag when not in use.

Interview on 03/30/11 at 11:37am with RN #1 revealed oxygen tubing is to be changed on Thursday during the night shift. It was unknown to RN #1 if this was documented. It was stated oxygen tubing should be dated and both oxygen cannulas and nebulizer masks should be stored in a plastic bag when not in use. In addition, IV tubing was to be changed every twenty-four (24) hours and should be timed and dated.

Interview on 03/30/11 at 10:35am with RN #2 revealed oxygen tubing was changed weekly and each unit had their own night to change the tubing.

Interview on 03/30/11 at 10:45am with Unit Coordinator revealed the night shift was to use a check off sheet which states to be changed oxygen tube weekly and date.

Interview on 04/01/11 at 2:30pm with the Administrator revealed that all staff had attended the annual infection control in-service.

{F 490} 483.75 EFFECTIVE
SS=E ADMINISTRATION/RESIDENT WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial

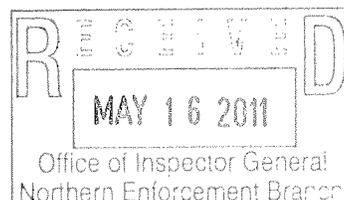
{F 441} The system changes that the facility put into place include:

- The Patient Information Worksheet is used to identify those residents with catheters, IV's, nebulizers, and oxygen.
- The Licensed nurse will monitor to ensure tubing is labeled and stored per infection control policies as well as appropriate storage and handling of urinals.

How does the facility plan to monitor its performance to ensure that solutions are sustained?

The ADNS or DCD's will conduct infection control rounds beginning May 9, 2011 for 4 weeks utilizing the QAA Infection Control Audit Tool to identify any issues with storage or labeling of equipment. Results of rounds will be documented and trended to identify any patterns or additional items that need to be addressed. The trended information will be presented to the QAA Committee monthly for additional recommendations.

{F 490}



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{F 490}

Continued From page 25 well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, pain process, pain guides, and the AOC it was determined that Immediate Jeopardy (IJ), identified during the abbreviated survey (04/06/11) had been removed; however, non-compliance continued to exist related to administration regarding the pain assessment process. The facility failed to ensure staff effectively implemented the facility's pain process flowchart in order to effectively manage residents pain for three (3) of seven (7) sampled residents, Residents #3, #4 and #7.

The findings include:
Refer to F157, F281, F309, and F520.

Review of the Pain Process Guide revealed patients were evaluated daily for evidence of pain. A pain evaluation was also completed before and after routine and PRN pain medication administration. The patients pain scale score was recorded on the Medication Administration Record (MAR).

The Allegation Of Compliance (AOC) dated 04/18/11 stated patient pain scores would be monitored daily in the Eagle Room (interdisciplinary team meeting) to identify appropriate assessment and treatment for pain is in place. The facility Director of Clinical Delivery (DCD's) will audit and verify completion of the required information daily and report to the Administrative Director of Nursing Services

{F 490}

F 490

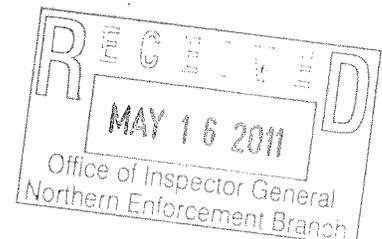
It is the facility practice that the center will be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident's #3, and #7 have been discharged from the facility.

Resident #4 has been assessed by the Director of Care Delivery (DCD) of the unit and a current accurate pain evaluation identifying location of pain, type of pain, which pain scale to be used and additional descriptive information regarding resident's pain and current treatment. Attending physician was notified as indicated for additional orders for pain control. Resident #4 care plan were revised as needed. Continued monitoring of

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{F 490}

Continued From page 26
(ADNS). The ADNS will randomly audit compliance with the process daily and submit findings to the Quality Assessment and Assurance (QA&A) committee daily meeting (Eagle Room Process). The Administrator will complete a daily audit of pain using the established pain tracking tools. The Director of Rehab (DOR) will complete an audit of therapists' notes, communication and process compliance. She will report her findings to the daily QA&A meeting.

Record review of Resident #3's Medication Administration Record (MAR) for the month of April, 2011 revealed from 04/21/11 through 04/25/11, there were eleven (11) opportunities for a pain evaluation to be completed by the facility, of the eleven (11) opportunities, the intensity was not utilized by the facility one (1) time.

Record review of Resident #4's MAR for the month of April 2011 revealed from 04/18/11 through 04/25/11, there were fifteen (15) opportunities to conduct a pre and post pain score of the fifteen (15) opportunities, the intensity was not utilized by the facility six (6) times.

Record review of Resident #7's MAR for the month of April 2011 revealed on two (2) occasions, it was documented the PRN medication Baclofen 10mg was given for complaints of pain to left hip. There was no documented evidence a pre or post pain score was conducted. Refer to F309

Interview with a Licensed Practical Nurse (LPN) #7 on 04/25/11 at 9:33am revealed the nursing

{F 490}

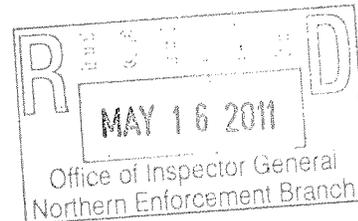
effectiveness of pain regimen continues with pre and post pain scores obtained and documented in the medication administration record (MAR) as indicated. The licensed nurse will follow the plan of care when documenting location, intensity and descriptor of pain when giving the as needed pain medication. Initial documentation was completed on or before April 2, 2011 and continued monitoring is ongoing.

How will you identify other residents having the potential to be affected by the same deficient practice?

Current and newly admitted residents have the potential to be affected.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

In-service training for licensed nurses was completed on or before 4/17/11 by the Quality



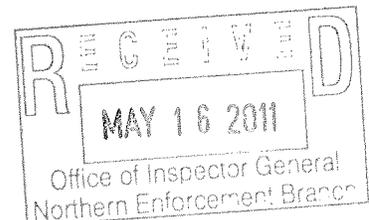
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| {F 490} | <p>Continued From page 27</p> <p>staff were inserviced on charting pre and post scores on MAR's. LPN #7 further stated pre and post scores should be documented in nursing notes.</p> <p>Interview with LPN #8 on 04/26/11 at 3:55pm revealed that when a resident complains of pain, the pain is assessed for the intensity; one (1) to ten (10), location of the pain and the type of pain. Complaints of pain should always be assessed and documented. LPN #8 further stated pre and post pain scores should be done on all PRN medications.</p> <p>Interview with the Administrative Director of Nursing Services (ADNS) on 04/26/11 at 5:00pm revealed that once residents were identified as having pain issues, the patients pain will be monitored day by day. Trends of each patient are assessed to make sure there are no documented increase in pain. ADNS further stated the facility nurses have been trained when a pain score increases, the staff are to reassess the resident's pain and investigate further. The ADNS stated the charge nurse (DNS) is responsible to make sure nurses are completing daily audits. The ADNS further stated the only audits that she completes are the pain audit tool for completion. She indicated she did not go through and check to see that each resident's pain score documented in the nurses notes, MAR and twenty-four hour report are accurately recorded on the pain auditing tool by the DNS. The ADNS further stated there are just to many residents to complete this task.</p> <p>Interview with the Director of Clinical Services on 04/26/11 at 6:00pm revealed that it was there</p> | {F 490} | <p>Improvement Specialist who is a Registered Nurse. Educational content consisted of the Pain Practice Guide to include:</p> <ul style="list-style-type: none"> • Initial Evaluation of pain upon admission • Pain Rating Scales • Pain Descriptions • Types of Pain • Initial and Comprehensive Care Plans • Ongoing Pain Management Strategies • Utilization of the SBAR as indicated • Patient and Family Education • Notification of Changes to Physician and Family <p>Amendments to the QAA evaluation process include the following: The IDT meeting agenda was revised on 4/2/11 by the LNHA to require in person attendance of the DOR or a therapist assigned to be the lead therapist in her absence to communicate any pain that had been previously noted in therapy to the nursing department for follow up as well as notification at the time of the resident's complaint of pain to the licensed nurse.</p> | |



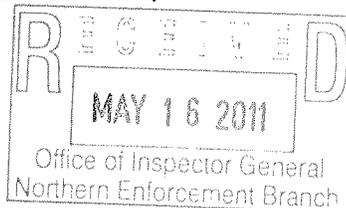
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| {F 490} | Continued From page 28 policy to do pre and post pain scores on PRN pain medication. Interview with the Administrator on 04/26/11 at 6:00pm revealed the only audits completed by her are the auditing tools used in QA&A. The Administrator further stated that she does not audit the ADNS or the DNS to make sure they are completing there assigned jobs. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/23/11. The state agency verified Immediately Jeopardy was removed during the onsite survey of 04/25-26, 2011, which lowered the scope and severity to a "E" at F490 while the facility's Quality Assurance monitors the effectiveness of audit tools for pain scores, pain process tools, and pain tracking to identify if appropriate assessment and treatment are in place. | {F 490} | The Eagle Room Pain Process Tool was revised to monitor residents with identified pain to ensure the resident's pain goal is achieved and/or additional interventions are initiated. The areas that will be addressed are: <ul style="list-style-type: none">• Pain occurrence evaluation• Resident education to Pain Descriptors• Physician and family notification• Referrals• Interventions• Care Plan Development Additional in-servicing training for Administrative, Nursing, Therapy, Housekeeping/Laundry, Dietary was completed on or before May 16, 2011 by the Quality Improvement Specialist who is a Registered Nurse on the location of the facility Pain Practice Guide and the Eagle Room Process and review of said processes. Copies of the Pain Practice Guide and Eagle Room Process have been placed at each nursing unit and in the therapy gym. | |
| {F 520} SS=E | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. | {F 520} | Amendments to the QAA evaluation process include the following: The IDT meeting agenda was revised | |



on 4/2/11 by the LNHA to require in person attendance of the DOR or a therapist assigned to be the lead therapist in her absence to communicate any pain that had been previously noted in therapy to the nursing department for follow up as well as notification at the time of the resident's complaint of pain to the licensed nurse.

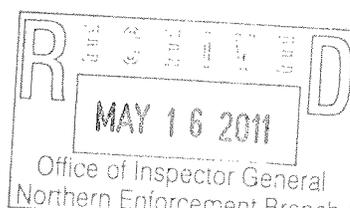
How does the facility plan to monitor its performance to ensure that solutions are sustained?

Resident's pain scores will be monitored by the IDT utilizing the Pain Process tool, the Pain Management Tracking tool and the 24 hour Report to identify appropriate assessment, treatment, interventions and notification to the attending physician if pain is not relieved.

The Directors of Care Delivery (DCD) will utilize the QAA Pain Audit tool to monitor those patients identified during the daily IDT meeting as having an increase in pain or a new onset of pain. The Audit will be completed beginning May 2, 2011 for 4 weeks unless deemed otherwise by the QAA Committee.

The Administrative Director of Nurses (ADNS) will validate the accuracy of audits completed by the DCD's by comparing audit results with patient record and completion of QAA Pain Audit tool. The Audit will be completed beginning May 2, 2011 for 4 weeks unless deemed otherwise by the QAA Committee.

The QAA Eagle Room Pain Process Tool and the Pain Management Tracking Tool will be evaluated by the Quality Assurance and Assessment Committee Chairman for areas of non-compliance weekly

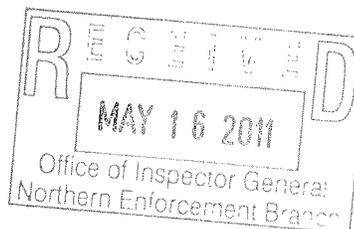


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until deemed corrected by the QAA Committee to determine if enhancements to the process are indicated. The QAA Committee members include the LNHA, the Assistant Administrator, the ADNS, DCD's, Social Workers, Dietitians, and the Human Resources Director. Areas of trending will include assessment, documentation, inter-department communication, physician and family notification, and treatment of patient pain beginning 4/15/11.

The Clinical Consultant will complete a compliance audit of both nursing and therapy processes utilizing the QAA Pain Audit Tool monthly x 6 months beginning 4/15/11. The Pain Audit Tool will monitor:

- Completion of Daily Pain score on MAR
- Completion of Pain Evaluation as needed
- Completion of SBAR as needed
- Notification of MD and Family
- Transcription of Pain medication orders
- Care plan completion/revision
- Documentation of pre and post pain scores with PRN pain medications
- Documentation of location and descriptor of pain when PRN pain medications are given



29B

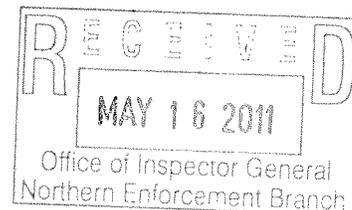
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| {F 520} | <p>Continued From page 29</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview record review and the Pain Practice Guide, it was determined that the facility failed to ensure staff effectively implemented the facility's pain auditing tool and pain process flowchart in order to effectively manage residents pain. The facility failed to complete a quality assessment which depicted an accurate account of Resident #2, #3, #4 and #7's pain, for four (4) of seven (7) sampled residents.</p> <p>The findings include:</p> <p>The Pain Practice Guide; Quality Assessment and Assurance (QAA) section revealed the pain prevention or reduction process is routinely audited through the utilization of the QAA audit tools to identify potential or actual system issues. The results of the audits are submitted to the QAA committee for review and follow-up as clinically indicated. Change in Condition section states if a change in patient condition occurs, the licensed nurse re-evaluates the intensity, location, type and history of pain and document findings in the progress notes of the patients clinical record. Based upon this evaluation, the physician is</p> | {F 520} | <p>F 520</p> <p>It is the Facility practice to maintain a Quality Assessment and Assurance Committee consisting of the Director of Nursing Services, a physician designated by the facility and at least 3 other members of the facility's staff.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident's #2, #3 and #7 have been discharged from the facility. Residents #4 was assessed by the Director of Care Delivery (DCD) of the unit and a current accurate pain evaluation identifying location of pain, type of pain, which pain scale to be used and additional descriptive information regarding resident's pain and current treatment. Attending physician was notified as indicated for additional orders for pain control by the DCD. Resident #4 care plan was revised as needed by the DCD's. Continued monitoring of effectiveness of pain regimen continues with pre and post pain scores obtained and</p> | 5/16/11 |



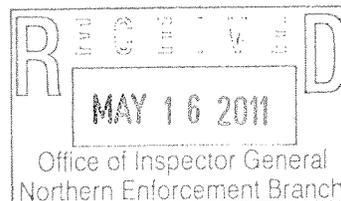
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R-C 04/26/2011 |
|--|--|--|---|

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|---|---|
| NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220 |
|---|---|

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| {F 520} | <p>Continued From page 30</p> <p>notified to obtain orders if indicated. The patients plan of care is reviewed and updated to reflect current care delivery needs. Eagle Room Review section revealed patients with pain are reviewed in Eagle Room daily. Results are tracked on the Eagle Room Pain Tool and on the Pain Management Tool as indicated and submitted to the QAA Committee for review.</p> <p>Interview with the DCD #1 on 04/26/11 at 10:35am revealed she audits the PRN pain scores, therapy notes off the twenty-four (24) hour report, nurses notes, SBAR and if the MD and the family were called. DCD #1 further stated the pain score of ten (10) on the SBAR was missed because there new system indicates that they identify if the SBAR was completed, it does not indicate to evaluate if a score was given on the SBAR. DCD #1 also stated that she can see that the SBAR scores need to be incorporated into the process.</p> <p>Interview with the Administrative Director of Nursing Services (ADNS) on 04/26/11 at 5:00pm revealed that once residents were identified as having pain issues, the patients pain will be monitored day by day. Trends of each patient are assessed to make sure there are no documented increase in pain. ADNS further stated that they are training staff that if a pain score spikes up, the staff are to reassess pain and investigate further. The ADNS stated the charge nurse Director of Clinical Delivery (DCD) was responsible to make sure nurses were completing daily audits. The ADNS further stated the only audits that she completes are the pain audit tool for completion, she does not go through and check to see that each resident's pain score</p> | {F 520} | <p>documented in the medication administration record (MAR) as indicated. The licensed nurse will follow the plan of care when documenting location, intensity and descriptor of pain when giving the as needed pain medication. Initial documentation was completed on or before May 2, 2011 and continued monitoring is ongoing.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice?</p> <p>Current and newly admitted residents have the potential to be affected.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>In-service training for licensed nurses was completed on or before 4/17/11 by the Quality Improvement Specialist who is a Registered Nurse. Educational content consisted of the Pain</p> | |



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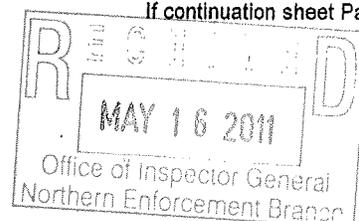
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| {F 520} | <p>Continued From page 31</p> <p>recorded in the nurses notes, MAR and twenty-four hour report are accurately documented on the pain auditing tool by the DCD. The ADNS further stated there are just to many residents to complete this task.</p> <p>Interview with the Director of Clinical Services on 04/26/11 at 6:00pm revealed that it was there policy to do pre and post pain scores on PRN pain medication.</p> <p>Interview with the Administrator on 04/26/11 at 6:00pm revealed the only audits completed by her are the auditing tools used in QA&A. The Administrator further stated that she does not audit the ADNS or the DNS to make sure they are completing there assigned jobs.</p> <p>The QAA pain audit tool, pain process tool and the pain management tracking tool will be evaluated by QAA committee members for all areas of non-compliance. A compliance audit will be reviewed monthly for six months.</p> | {F 520} | <p>Practice Guide to include:</p> <ul style="list-style-type: none"> • Initial Evaluation of pain upon admission • Pain Rating Scales • Pain Descriptions • Types of Pain • Initial and Comprehensive Care Plans • Ongoing Pain Management Strategies • Utilization of the SBAR as indicated • Patient and Family Education • Notification of Changes to Physician and Family <p>Amendments to the QAA evaluation process include the following: The IDT meeting agenda was revised on 4/2/11 by the LNHA to require in person attendance of the DOR or a therapist assigned to be the lead therapist in her absence to communicate any pain that had been previously noted in therapy to the nursing department for follow up as well as notification at the time of the resident's complaint of pain to the licensed nurse.</p> <p>The Eagle Room Pain Process Tool was revised to monitor residents</p> | |
|---------|---|---------|---|--|



with identified pain to ensure the resident's pain goal is achieved and/or additional interventions are initiated. The areas that will be addressed are:

- Pain occurrence evaluation
- Resident education to Pain Descriptors
- Physician and family notification
- Referrals
- Interventions
- Care Plan Development

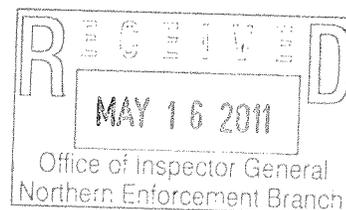
In-servicing training for the LNHA, ADNS, Licensed Nurses, and therapy Department was completed on or before May 2, 2011 by the Quality Improvement Specialist who is a Registered Nurse on the location of the facility Pain Practice Guide and the Eagle Room Process and review of said processes. Copies of the Pain Practice Guide and Eagle Room Process have been placed at each nursing unit and in the therapy gym.

In-servicing training for the LNHA, ADNS, and Medical Director was completed by 4/17/11 by the Acting Regional Director of Operations. Educational content consisted of the company's Quality Assessment and Assurance Committee Guidelines as well as Federal Regulation 520.

In-service training for Administrative Nursing, Housekeeping/Laundry, Dietary, and May 16, 2011 by the Quality Improvement Specialist who is a Registered Nurse. Educational content consisted of the company's Quality Assessment and Assurance Committee Guidelines.

How does the facility plan to monitor its performance to ensure that solutions are sustained?

Resident's pain scores will be monitored by the IDT utilizing the Pain Process tool. the Pain



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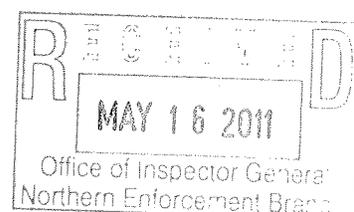
Management Tracking tool and the 24 hour Report beginning 4/2/11 to identify appropriate assessment, treatment, interventions and notification to the attending physician if pain is not relieved.

The Directors of Care Delivery (DCD) will utilize the QAA Pain Audit tool to monitor those patients identified during the daily IDT meeting as having an increase in pain or a new onset of pain. The Audit will be completed beginning May 2, 2011 for 4 weeks unless deemed otherwise by the QAA Committee.

The Administrative Director of Nurses (ADNS) will validate the accuracy of audits completed by the DCD's by comparing audit results with patient record and completion of QAA Pain Audit tool. The Audit will be completed beginning May 2, 2011 for 4 weeks unless deemed otherwise by the QAA Committee.

The QAA Eagle Room Pain Process Tool and the Pain Management Tracking Tool will be evaluated by the Quality Assurance and Assessment Committee Chairman for areas of non-compliance weekly until deemed corrected by the QAA Committee to determine if enhancements to the process are indicated. The QAA Committee members include the LNHA, the Assistant Administrator, the ADNS, DCD's, Social Workers, Dietitians, and the Human Resources Director. Areas of trending will include assessment, documentation, inter-department communication, physician and family notification, and treatment of patient pain beginning 4/15/11.

The Clinical Consultant will complete a compliance audit of both nursing and therapy processes utilizing the



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QAA Pain Audit Tool monthly x 6 months beginning 4/15/11. The Pain Audit Tool will monitor:

- Completion of Daily Pain score on MAR
- Documentation by therapy on 24 hour report and line progress notes
- Completion of Pain Evaluation as needed
- Completion of SBAR as needed
- Notification of MD and Family
- Transcription of Pain medication orders
- Care plan completion/revision
- Documentation of pre- and post pain scores with PRN pain medications
- Documentation of location and descriptor of pain when PRN pain medications are given

Validation of understanding of the Pain Practice Guide, the Eagle Room Process, and the QAA Process with the facility staff will be completed weekly x 4 weeks beginning May 9, 2011 by the LNHA, ADNS, or DOR utilizing the QAA Pain/Eagle Room/QAA Questionnaire.

The QAA Pain/Eagle Room/QAA Questionnaire will be evaluated by the Quality Assurance and Assessment Committee Members for areas of non-compliance weekly until deemed corrected by the QAA Committee to determine if enhancements to the process are indicated.

