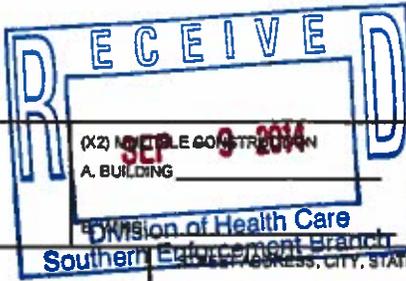


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/20/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED C 08/06/2014
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NAME OF PROVIDER OR SUPPLIER DANVILLE CENTRE FOR HEALTH AND REHABILITATION	ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422
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F 000	INITIAL COMMENTS An abbreviated survey (KY22023) was initiated on 07/31/14 and a standard health survey was initiated on 08/04/14 and concluded on 08/06/14. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	The plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	1. On 8/6/14 the Unit Manager/Director of Nursing contacted the Resident # 17 MD regarding the omission/refusal of the Lactulose dosages on 8/4/14 4:00 pm and 8:00. The MD gave no new orders and stated continue dosage as ordered. The family of Resident #17 was notified on 8/6/14 of the omission/refusal of the Lactulose. LPN #5 was educated related to Medication Administration, Medication Administration General Guideline, Notification of Change to resident's physician and responsible party. 2. All MARS and TARS were reviewed for omissions/refusals on 8/6/14. There were no other issues noted. 3. Starting on 8/6/14, at the end of each shift change the licensed staff will run a report of omission from the eZMAR and address any noted issues by notifying physician and family if there are 2 omissions/refusals. Licensed staff will then take any new orders obtained from the physician and notify responsible party. Resident, Resident Physician and responsible party will be notified of any change in condition, treatment or transfer/discharge.	8/31/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cheryl Thayer* TITLE: *Nursing Home Administrator* DATE: *8/28/14*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure facility staff notified and consulted with the physician when two (2) consecutive doses of a vital medication were held or refused for one (1) of twenty-four (24) sampled residents (Resident #17). Review of the medical record for Resident #17 revealed the physician had prescribed 30 milliliters (ml) of Lactulose (laxative) to be administered four (4) times a day for the resident due to the resident's diagnosis of Cirrhosis of the Liver. Observation of the medication pass on 08/04/14 at 4:30 PM revealed staff did not administer the 30 milliliters of Lactulose to Resident #17 because the resident reportedly had loose stools. In addition, review of the electronic Medication Administration Record (eMAR) revealed the resident had also refused the medication on 08/04/14 during the 8:00 PM medication pass. However, interview and a review of documentation revealed facility staff failed to notify the physician that the resident had refused two (2) consecutive doses of a vital medication.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Medication Administration General Guideline," (December 2012) revealed if two consecutive doses of a vital medication were withheld or refused, the physician was to be notified.</p>	F 157	<p>A room change form is utilized to notify all parties involved of a room change. The Social Services Director and/or designee will notify the resident and responsible party of any change in room assignment. The Social Services Director will notify residents and responsible parties of any change in resident rights under Federal or State law. The responsible parties are asked to review and update contact information during quarterly care plan meeting. There is a quarterly reminder in the monthly newsletter sent to the responsible parties reminding them to update contact information any time there is a change.</p> <p>On 7/26/14 through 8/6/14 daily medication administration audits were completed with 3 nurses. No issues noted.</p> <p>Pharmacy completed an audit of physicians orders, electronic MAR, cart audits the week of 8/11/14-8/15/14. Pharmacist also completed Medication Administration Audits with Licensed staff.</p> <p>All licensed staff have been educated on Medication Administration, Medication Administration General Guidelines, Notification of change, and have been observed by Staff Development Coordinator for Medication Administration.</p>		

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F 157	<p>Continued From page 2</p> <p>A review of Resident #17's medical record revealed the facility admitted the resident on 05/01/12 with diagnoses that included Cirrhosis of the Liver, Metastatic Cancer of the Liver, Vitamin Deficiency Anemia, and Diabetes. Review of the physician's orders dated July 2014 revealed staff was to administer 30 ml of Lactulose to the resident, four times a day, for the diagnosis of Cirrhosis of the Liver.</p> <p>Observation on 08/04/14 at 4:30 PM of the medication pass on Hall 2 revealed Licensed Practical Nurse (LPN) #5 did not administer the 30 ml of Lactulose to Resident #17 because the resident reportedly had loose stools. LPN #5 documented on the MAR that the resident had refused the medication.</p> <p>In addition, review of the eMAR revealed LPN #5 had also documented Resident #5 had refused the following dose of Lactulose that was to be administered on 08/04/14 at 8:00 PM.</p> <p>Interview with LPN #5 on 08/04/14 at 4:30 PM and on 08/06/14 at 2:50 PM revealed the Lactulose had been prescribed by the physician due to the resident's diagnosis of Cirrhosis of the Liver because the effects of medication aided in the reduction of the ammonia levels in the resident's system. The LPN acknowledged she withheld the medication and documented the resident had refused the two consecutive doses of medication due to loose stools. LPN #5 stated she had not notified the resident's physician of the resident's refusal of the medication prior to withholding the medication at 4:00 PM and at 8:00 PM on 08/04/14.</p> <p>Interview with the Unit Manager/Director of</p>	F 157	<p>4. The Unit Mangers/ADONs or designee are responsible for their unit to ensure the Medication is administrated per MD order and any omissions/refusals are reported to the physician and responsible party Monday -Friday. The Weekend Nursing Supervisor or designee is responsible for this action on Saturday-Sunday. Any findings will be discussed by the Interdisciplinary team IDT (may include Administrator, DON, Social Services, Dietary Manager, Unit Managers, MDS Coordinators, Quality of Life) during morning meeting to ensure proper notification has been completed. Beginning 8/7/14 for 4 weeks the SDC, DON or other Designee will complete 3 Medication Administration Audits per week, then 2 per week for 4 weeks, then 1 per week for 4 weeks. Any identified issue/trends will be taken to the Quality Assurance Performance Improvement for three months until substantial compliance is achieved and as needed thereafter. The members of QAPI include: Administrator, DON, ADON, Medical Director, Social Services Director, Dietary Manager, Quality of Life Director, CNA, Housekeeping, Plant Operations Director, Human resources. Substantial compliance will be achieved by 8/31/14.</p>		

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F 157	Continued From page 3 Nursing on 08/06/14 at 2:50 PM revealed the Lactulose had been prescribed for Resident #17 to treat the resident's diagnosis of Cirrhosis of the Liver. According to the Unit Manager/Director of Nursing, the LPN should have informed the physician of the resident's refusal of two consecutive doses of the medication due to loose stools.	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	1. On 7/24/14, when the Administrator and Regional Team were notified of the allegation of abuse/neglect, LPN #1, DON and ADON were suspended immediately. OIG, APS, MD, Ombudsman, Resident's Guardian were notified of the alleged allegation and a full investigation was initiated. Resident #1 was assessed for any signs/symptoms of abuse/neglect, no concerns were noted. The final investigation was submitted to OIG, APS and the Ombudsman on 7/28 /14. LPN #1, DON and ADON are no longer employed at Danville Centre. 2. On 7/24/14 All residents with a BIMS of 8 or above were interviewed to ensure nursing was administering their medication correctly or if they had any care concerns which could be potential abuse/neglect. These residents had no concerns noted. All resident with with a BIMS of 7 or below had a skin assessment completed to check for signs/symptoms of abuse/neglect. There was no indication of abuse/neglect noted from the skin assessments. All residents Medication Administration records were checked to ensure the resident's medication was being administered appropriately. Human Resources completed an audit of all employee files to ensure appropriate back-	8/31/14	

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F 225	<p>Continued From page 4</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure an allegation of neglect was reported immediately to the administrator of the facility, and to the appropriate state agencies in accordance with state law, for one (1) of twenty-four (24) sampled residents (Resident #1). In addition, the facility failed to ensure all alleged violations were investigated and that further potential abuse was prevented while the investigation was in progress. On 07/22/14, Registered Nurse (RN) #1 reported to the facility's Director of Nursing (DON)/Assistant Director of Nursing (ADON) that Licensed Practical Nurse (LPN) #1 failed to administer medications to Resident #1. However, the facility failed to investigate the allegation of neglect, failed to protect residents from further potential neglect, and failed to notify the appropriate state agencies of the reported neglect until 07/24/14, two days later.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Abuse, Neglect and Misappropriation," (dated April 2013) revealed all allegations of neglect should be</p>	F 225	<p>ground screen was completed prior to hiring staff. There were no issues noted. Completed on 7/29/14.</p> <p>On 7/28/14, Interim DON, Staff Development MDS Staff, Medical Records and Social Service Director, began reviewing all current resident's documentation in the nurses notes and social services notes for any documented evidence of an allegation of abuse/neglect. There was one resident concern noted on 8/1/14, this was immediately reported to OIG, APS, Ombudsman, Physician and guardian. The final investigation was submitted on 8/6/14.</p> <p>3. Beginning on 7/24/14 all staff members were educated on the abuse policy and procedure regarding Neglect, to include but not limited to: training, prevention, identification of neglect, protection and reporting/response. All staff were give a pre and post test If the employee did not score 100% on the post -test, the employee was immediately re-educated and post-test administered. This process continued until employees obtain 100% score on the post test</p> <p>On 8/2/14 The Interim DON, Staff Development MDS Staff, Medical Records and Social Service Director began auditing 10 charts per per day for any documented evidence of an allegation of abuse/neglect through 8/13/14. There were no concerns identified. Beginning on 8/14/14 for 4 weeks we will audit 10 charts per week, then 5 chart audits for 4 weeks. Human Resources will randomly audit 20 employee files for 4 weeks (5 per week). Ther</p>		

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F 225	<p>Continued From page 5</p> <p>reported immediately to the charge nurse/and or administrator of the facility along with other officials in accordance with state law through established guidelines. The facility was to remove the suspected perpetrator from resident care areas, obtain the staff members' witness statements, and immediately suspend the employee pending the outcome of the investigation.</p> <p>Review of Resident #1's medical record revealed the facility admitted Resident #1 on 08/12/11 with diagnoses that included Anoxic Brain Injury, Persistent Vegetative State, Muscle Spasms, Involuntary Movements, and Latent Effects of Electric Current. According to the medical record Resident #1 was cognitively impaired and required meals, fluids, and medications to be administered through a gastrostomy tube (G-tube).</p> <p>Review of the facility's investigation report revealed on 07/22/14 Registered Nurse (RN) #1 reported to the facility's Director of Nursing (DON) and Assistant Director of Nursing (ADON) that Licensed Practical Nurse (LPN) #1 failed to administer medications to Resident #1 on 07/22/14. However, continued review of the report revealed the facility failed to report the allegation to the appropriate state agencies, failed to initiate an investigation of the allegation, and failed to ensure all residents were protected from further potential neglect until two days later, 07/24/14, when RN #1 reported the allegation to the facility corporation's hotline.</p> <p>Interview with RN #1 on 07/31/14 at 3:30 PM revealed on 07/22/14, when conducting a count of narcotic medications, she observed a cup of</p>	F 225	<p>10 for 4 weeks (3 per week +1).</p> <p>4. The Interim DON, Staff Development MDS Staff, Medical Records and Social Service Director completed 10 daily chart audit on 8/13/14. They will continue for 4 weeks auditing 5 charts each week for any documentation of potential abuse/neglect, then 3 per week for 4 weeks.</p> <p>Beginning 8/6/14 Human resources will audit 20 employee files over 4 weeks, the 10 over 4 weeks and then 5 for 4 weeks.</p> <p>Interviews and skin assessments with resident to ensure there are no signs/symptoms of abuse or neglect.</p> <p>Beginning 7/26/14 Resident interviews with BIMs 8 and and above and skin assessment for residents with BIMs 7 and below 10 resident interviews and 10 skin assessments for 4 weeks, then 5 interviews and 5 skin assessments for 4 weeks, and then 3 interviews and 3 skin assessments for 4 weeks.</p> <p>These audits will be completed by Administrator, DON, ADON, SSD, RD, Quality of Life Staff and or Designee.</p> <p>Any identified issue/trends will be taken to the Quality Assurance Performance Improvement for three months or until substantial compliance is achieved and as needed thereafter. The members of QAPI include: Administrator, DON, ADON, Medical Director, Social Services Director, Dietary Manager, Quality of Life Director,</p>		

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F 225	<p>Continued From page 6</p> <p>liquid medication in the medication drawer of Resident #1. RN #1 said the liquid in the medication cup was brown in color, had an orange tint, and smelled like multivitamins and ferrous sulfate (iron). According to RN #1, LPN #1 (who had worked the first shift and had given medication from the medication cart) said the medications were Resident #1's medications that had been due at 8:00 AM that morning, and that she would administer the medication to the resident as she left for the day. However, according to RN #1, when she completed the count of the narcotics in the medication cart, she observed LPN #1 go outside the back door and throw something in the garbage can by the back door (outside of the building). RN #1 said she went to the outside garbage can by the back door and saw the cup of medication that had been in the medication drawer and observed some of the medication had spilled out into the garbage can. RN #1 stated she obtained the cup, placed it in a latex glove, and reported the incident to the DON and the ADON at 3:30 PM. RN #1 said the DON and ADON did not interview staff related to the incident and did not initiate an investigation into the incident. RN #1 stated she reported the allegation to the corporate hotline because the DON and ADON didn't initiate an investigation and it did not look like they were going to address her concerns about the care that LPN #1 provided.</p> <p>interview with LPN #1 on 08/01/14 at 10:27 AM revealed the LPN had administered medication on 07/22/14. LPN #1 said she forgot about the 8:00 AM (gastric tube) G-tube medications for Resident #1 until the shift change when she was asked about the medication cup in the medication drawer by RN #1. At that time, according to LPN</p>	F 225	CNA, Housekeeping, Plant Operations Director, Human resources. Substantial compliance will be achieved by 8/31/14.		

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F 225	<p>Continued From page 7</p> <p>#1, she told RN #1 she would give the 8:00 AM medications on her way out of the facility. LPN #1 stated the medications in the cup were Baclofen (muscle relaxant), Docusate (stool softener), multivitamin, and Dantrolene (muscle relaxant). LPN #1 said the 8:00 AM medications were given to Resident #1 at approximately 2:45-3:00 PM as she left the facility and she threw the empty cup into the garbage can outside the back door of the facility. LPN #1 stated when she returned to work on 07/23/14, she was given a written reprimand from the Assistant Director of Nursing (ADON) for omission of medications and was given an in-service on medication administration. In addition, LPN #1 stated the ADON observed her administer the morning medications to resident on 07/24/14. However, LPN #1 said she was suspended pending an investigation on 07/24/14, was escorted out of the building, and was then terminated.</p> <p>Interview with the Director of Nursing (DON) on 08/01/14 at 9:45 AM revealed she was notified on 07/22/14 by RN #1 that LPN #1 had not given a cup of medications for Resident #1 and had thrown the medications into the trashcan outside the back door. According to the DON, RN #1 presented a Dixie cup of liquid medications in a rubber glove that smelled like Multivitamin and Ferrous Sulfate. The DON stated that LPN #1 told RN #1 that she had forgotten to give Resident #1's 8:00 AM medications, but would give the medications on her way out. The DON stated she and the ADON looked at the eMARs and saw the medications were initialed as being given, and there were no omitted doses noted. The DON stated she told the ADON to give LPN #1 a written reprimand for omitting medications, to in-service LPN #1 on medication</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>administration, and to follow LPN #1 on a medication administration pass. According to the DON, the written reprimand was given to LPN #1, the in-service was completed, and the ADON observed medication pass on the morning of 07/24/14. LPN #1 was suspended on 07/24/14 pending an investigation and escorted out of the building at 2:15 PM, and then terminated by the facility. The DON said the administrator was not in the building at the time and since she and the ADON did not feel as if the incident was abusive or neglectful, they did not notify the administrator. The DON said, "I viewed the incident as a missed medication dose, not as abuse, so no investigation was started, and the administrator or state agencies were not notified."</p> <p>Interview with the ADON (Assistant Director of Nursing) on 08/01/14 at 10:44 AM revealed RN #1 told the DON and the ADON that LPN #1 had thrown away a cup of medications outside the back door of the building that should have been administered to Resident #1. The ADON stated RN #1 had reportedly retrieved the medication cup from the garbage, placed the cup in a rubber glove, and had shown it to the DON/ADON. According to the ADON, the medication cup was approximately one-fourth full of a brown liquid that smelled like Multivitamin and Ferrous Sulfate. The DON threw the cup and rubber glove into the garbage in the biohazard room. The ADON said she and the DON had not viewed the incident as neglect and considered the incident a medication error. According to the ADON, on 07/22/14, the DON asked the ADON to give LPN #1 a written reprimand related to the omitted medication, to in-service LPN #1 on medication administration, and to observe LPN #1 during a medication pass. The ADON gave LPN #1 a written reprimand on</p>	F 225			

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F 225	Continued From page 9 07/23/14, provided an In-service education to LPN #1, and observed LPN #1 administer medications on the morning of 07/24/14. The ADON said on 07/24/14 at 2:15 PM, LPN #1 was suspended pending an investigation and was escorted out of the building. Interview with Administrator #1 on 08/01/14 at 11:30 AM revealed she was not present in the building on 07/22/14. According to Administrator #1, the facility's corporate staff requested that she come to the facility because an abuse allegation had been made and the company had suspended the DON, the ADON, and LPN #1. According to Administrator #1, an investigation of the incident was initiated on 07/24/14, and the facility terminated the employment of LPN #1, the DON, and the ADON. Further review of the facility's investigation revealed the facility substantiated the allegation that LPN #1 neglected Resident #1. In addition, the facility substantiated that the DON and ADON failed to follow the facility's policy because they did not report the neglect allegation.	F 225			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the	F 282			

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F 282	<p>Continued From page 10</p> <p>facility failed to ensure services were provided in accordance with the plan of care for three (3) of twenty-four (24) sampled residents (Residents #1, #2, and #16). Resident #1's care plan indicated tube-feeding was administered per pump; however, observations on 07/31/14 from 10:30 AM until 3:10 PM revealed the tube-feeding had not infused. Resident #2's care plan indicated tube-feeding was administered per pump; however, observations on 07/31/14 from 10:25 AM until 3:05 PM revealed the tube-feeding had not infused. Resident #16's care plan indicated the resident used a splint to the left arm; however, observation on 08/06/14 revealed the resident did not have a splint to his/her left arm.</p> <p>The findings include:</p> <p>Review of the facility policy, "Care Plans-Comprehensive," (dated October 2010) revealed care plans were to include measurable objectives and timetables to meet the medical, nursing, mental, and psychological needs for each resident.</p> <p>1. A review of Resident #1's medical record revealed the facility admitted the resident on 08/12/11 and had diagnoses that included Anoxic Brain Injury and Persistent Vegetative State.</p> <p>Review of the comprehensive care plan revised on 07/09/14 revealed Resident #1 had lost weight and was at nutritional risk related to receiving tube-feeding and not receiving anything by mouth. The facility implemented interventions that included providing tube-feeding and water flushes to prevent further weight loss.</p> <p>Review of the electronic Medication</p>	F 282	<p>1. On 7/31/14 the physicians and families/ guardian of Resident #1 and # 2 were notified of a possible issue the tube feeding pumps may not be working appropriately. The physicians did not wish to order bolus feeding for Resident #1 and #2. Both of these tube feeding pumps were removed from service and replaced with other new Tube feeding pumps. The company who contracts the pumps was contacted and they sent a representative out on 8/1/14. A representative for the contract company stated these pumps in question were manufactured December 2012 and were not due a performance inspection until December 2014. On 7/31/14 An audit tool was put in place to ensure the tube feeding was being administered correctly and that the amount of tube feeding in the bottle was consistent with the pump reading. On 8/1/14 it was identified through the audits the amount of tube feeding on the bottle of Residents #1 and #2 was still not consistent with the current reading on the pump. The physicians of Residents # 1 and #2 were notified and new orders were obtained for bolus feedings. A new audit tool was then initiated on the bolus feedings on 8/1/14 to ensure nurse competency and to ensure the residents were receiving the appropriate amount of flush and tube feeding bolus.</p>		

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F 282	<p>Continued From page 11</p> <p>Administration Record (eMAR) for 07/31/14 revealed the first shift nurse (6:30 AM to 2:30 PM) documented Resident #1 had received 471 cc of tube-feeding. However, observations of Resident #1 on 07/31/14 at 10:30 AM, 11:40, 12:30 PM, 2:00 PM, and 3:10 PM revealed no tube-feeding was administered to the resident and 75 cc of water were administered. Observations revealed a 1500 cc bottle of Jevity 1.5 tube-feeding dated 07/31/14 at 9:40 AM (date and time the tube-feeding bottle was started) was hanging on a tube-feeding pump and the amount of feeding in the bottle did not decrease from 10:30 AM through 3:10 PM even though the tube-feeding pump indicated the feeding was set to infuse at 60 cc an hour with 125 cc of water every 4 hours.</p> <p>Interview with LPN #3 on 08/01/14 at 3:45 PM revealed Resident #1's tube-feeding pump was cleared (reset to zero) at the beginning of the shift on 07/31/14 (approximately 6:30 AM) and was routinely cleared three times per day at shift change. LPN #3 stated staff started a new bottle of tube-feeding sometime after staff cleared the pump on 07/31/14. LPN #3 further stated during the day shift on 07/31/14, Resident #1 received 471 cc of tube-feeding and 250 cc of water. She stated she documented the tube-feeding and water intake under "treatment" on the computer based on feeding pump readings. LPN #3 was not aware of any problems with the tube-feeding pumps or with tube-feeding infusing as ordered.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted Resident #2 on 03/09/12 with diagnoses including Dysphagia, Dementia, Psychosis, and Alzheimer's disease.</p> <p>A review of Resident #2's comprehensive care</p>	F 282	<p>On 8/7/14 a referral was made to therapy for resident # 16 regarding her range of motion and need for splint.</p> <p>2. All resident care plans have been audited by the MDS staff, Interim DON, Staff Development Coordinator, Medical records Registered Dietitian, Social Services Director and Quality of Life Director to ensure the comprehensive care plan for each resident includes measurable goals, objectives and timetables, to meet a residents medical, mental, nutritional, psychosocial needs and any splints or adaptive equipment was included on the care plan. A resident review was completed for all resident to ensure the care plans were implemented This was completed on 8/10/14.</p> <p>3. Education with the all Licensed staff was conducted on care plan polices and procedures and was completed on 8/16/14. The Interim DON, Unit Mangers, MDS staff, Weekend Supervisor and/or designee will review all new physicians order, 24 hour report daily to ensure care plans are reflective of any changes to the residents on a daily basis and educate staff to make them aware of changes, then audit to ensure implementation. All new orders and 24 hour report will be reviewed in morning meeting by the IDT to ensure care plans are being updated with any changes. The IDT will review all care plans on a quarterly basis with the MDS and care plan schedule to ensure they are updated with any changes.</p>		

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F 282	<p>Continued From page 12</p> <p>plan dated 04/03/14 revealed Resident #2 required tube-feedings for nutrition and the facility would administer tube-feedings and water flushes per physician orders.</p> <p>Review of Resident #2's electronic Medication Administration Record (eMAR) revealed Resident #2 received 784 cc of tube-feeding on 07/31/14. And interview with LPN #3 on 08/01/14 at 3:45 PM revealed Resident #2 received 310 cc of water and 428 cc of tube-feeding during the day shift on 07/31/14, according to the resident's tube-feeding pump.</p> <p>Observation of Resident #2 on 07/31/14 at 10:25 AM, 11:25 AM, 12:25 PM, 2:03 PM, and 3:05 PM revealed the tube-feeding pump was set to administer 55 cc per hour; however, the tube-feeding bottle remained at 1500 cc and no tube-feeding infused during the four hour and forty minute period.</p> <p>Interview with the Unit Manager (UM)/acting Director of Nursing (DON) on 07/31/14 at 5:15 PM revealed staff documented resident tube-feeding intake on eMARs and the UMs reviewed the documentation daily at the end of the shift (around 5:00 PM). According to the UM/acting DON, if documentation revealed that tube-feeding was not administered as ordered, the UMs talked with the nurses to see if the pumps were turned off for any reason. The UM/acting DON stated nurses should monitor to ensure tube-feeding pumps were on and working properly. The UM/acting DON stated she and the Unit Managers did not monitor to ensure tube-feeding pumps were working appropriately. The UM/acting DON further stated tube-feeding pumps were not easy to use at first, but the</p>	F 282	<p>4. Daily review of physicians orders and 24 hour report will be completed by the interim DON, Unit Mangers, Weekend Supervisor, MDS Staff, and/or designee to ensure the care plans are updated with any changes and implemented. Beginning on 8/11/14 The DON, Unit Managers, Weekend Supervisor, MDS staff and/or designee will audit the resident to ensure the care plans are implemented 5 per week for 4 week, the 3 per week for 4 weeks the 2 per week for 4 weeks. Any identified issue/trends will be taken to the Quality Assurance Performance Improvement for three months or until substantial compliance is achieved and as needed thereafter. Substantial compliance will be achieved by 8/31/14.</p>		

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F 282	<p>Continued From page 13</p> <p>nurses were having less trouble with the alarms going off on the pumps.</p> <p>3. Review of Resident #16's medical record revealed the facility admitted Resident #16 on 12/01/09 with diagnoses including Unspecified Hemiplegia, Cerebral Vascular Accident, Muscle Weakness, and Brain Injury.</p> <p>Review of Resident #16's Comprehensive Care Plan, initiated on 09/25/13, revealed the facility identified the resident had a problem related to complications of the resident's impaired range of motion. The facility developed interventions to address the problem that included the use of a splint to the left hand to prevent joint contractures.</p> <p>Review of Resident #16's most recent Quarterly Minimum Data Set (MDS) assessment dated 06/17/14 revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident's cognition was moderately impaired.</p> <p>Review of Resident #16's electronic Medication Administration Record (eMAR) dated 08/01/14 through 08/31/14 revealed nursing staff had documented Resident #16 had a splint present to the left hand on the day shift on 08/05/14.</p> <p>However, observations of Resident #16 on 08/06/14 at 11:59 AM and 12:48 PM revealed a splint was not present on Resident #16's left arm as planned.</p> <p>Interview with Resident #16 on 08/06/14 at 10:41 AM revealed he/she did not wear a splint on the left hand.</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 on 08/06/14 at 10:48 AM revealed SRNA #2 had observed the splint on the resident's left arm in the past, but could not recall when.</p> <p>Interview with SRNA #4 on 08/06/14 at 1:05 PM revealed for the four months that SRNA #4 had been working at the facility she had not seen the splint present on Resident #16's left arm. Further interview with SRNA #4 revealed SRNAs are not responsible for ensuring that devices such as splints are present on residents. SRNA #4 revealed either Restorative Nursing or Therapy was to ensure splints were used.</p> <p>Interview with LPN #3 on 08/06/14 at 2:50 PM revealed nurses were responsible to ensure splints were in use. LPN #3 stated she was Resident #16's nurse on 08/05/14 or 08/06/14 and had not applied the splint. Further interview with LPN #3 revealed it was her understanding the splint was to be applied sometime during the day and removed at night or when the resident requested that it be removed. LPN#3 stated she attempted to put the splint on Resident #16 between 7:00 AM and 8:00 AM on 08/06/14 but the resident had refused the splint. LPN#3 stated she did not follow up with Resident #16 that day to attempt to place the splint on again, but should have. LPN #3 did not document that the splint was not in place.</p> <p>Interview on 08/06/14 at 3:35 PM with the UM/acting DON revealed she checked the care plans and residents to ensure care was provided as planned, including the use of splints, and had not identified Resident #16 did not have a splint to</p>	F 282			

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F 282	Continued From page 15 the left hand as planned. In addition, the UM/acting DON stated that all department heads were supposed to make daily rounds to ensure care was provided as planned and that staff had not informed her of any problems.	F 282			
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's tube-feeding policy, it was determined the facility failed to ensure two (2) of twenty-four (24) sampled residents (Residents #1 and #2) received tube-feedings as required by the residents' plan of care and physician orders. Residents #1 and #2 had physician orders for tube-feeding to infuse continuously via a tube-feeding pump. Observations of Resident #1's tube-feeding formula on 07/31/14 from 10:30 AM until 3:10 PM and Resident #2's tube-feeding formula on 07/31/14 from 10:25 AM until 3:05 PM revealed no tube-feeding infused.	F 325	1. On 7/31/14 the physicians and families/ guardian of Resident #1 and #2 were notified of a possible issue the tube feeding pumps may not be working appropriately. The physicians did not wish to order bolus feeding for Resident #1 and #2. Both of these tube feeding pumps were removed from service and replaced with other new Tube feeding pumps. The company who contracts the pumps was contacted and they sent a representative out on 8/1/14. A representative for the contract company stated these pumps in question were manufactured December 2012 and were not due a performance inspection until December 2014. On 7/31/14 An audit tool was put in place to ensure the tube feeding was being administered correctly and that the amount of tube feeding in the bottle was consistent with the pump reading. On 8/1/14 it was identified through the audits the amount of tube feeding on the bottle of Residents #1 and #2 was still not consistent with the current reading on the pump. The physicians of Residents # 1 and #2 were notified and new orders were obtained for bolus feedings. A new audit tool was then initiated on the bolus feedings on 8/1/14 to ensure nurse competency and to ensure the residents were receiving the appropriate amount of flush and tube feeding bolus.	8/31/14	

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F 325	<p>Continued From page 16 The findings include:</p> <p>Review of the facility policy, "Nasogastric/Gastrostomy Tube-feedings" (dated December 2010) revealed facility staff was required to follow physician orders when administering tube-feeding to ensure the formula, rate, and hours of administration were followed.</p> <p>1. A review of Resident #1's medical record revealed the facility admitted the resident on 08/12/11. Resident #1 had diagnoses that included Anoxic Brain Injury and Persistent Vegetative State.</p> <p>Review of the comprehensive care plan revised on 07/09/14 revealed the resident was at nutritional risk related to receiving tube-feeding and not receiving anything by mouth. The facility implemented interventions that included providing tube-feeding and water flushes to prevent further weight loss.</p> <p>A review of Resident #1's physician orders dated 07/09/14 revealed an order for tube-feeding (Jevity) to be administered at 60 cubic centimeters (cc) per hour twenty-four hours per day via a tube-feeding pump.</p> <p>Review of the electronic Medication Administration Record (eMAR) for 07/31/14 revealed the first shift nurse (8:30 AM to 2:30 PM) documented Resident #1 had received 471 cc of tube-feeding.</p> <p>Observations of Resident #1 on 07/31/14 at 10:30 AM revealed a 1500 cc bottle of Jevity 1.5 tube-feeding dated 07/31/14 at 9:40 AM (date and time the tube-feeding bottle was started) was</p>	F 325	<p>2. All residents weights were reviewed by the Registered Dietitian from 3/1/14-8/3/14 for significant weight loss or gains, reviewed labs, adaptive equipment, supplements, location of dining,snacks and care plans for appropriate nutritional interventions. No other issues were noted.</p> <p>3. All resident weights will be reviewed on a monthly basis, any significant weight loss or gains will be placed on weekly weights and re-weights will be completed if indicated. The Registered Dietitian will review the weights for any significant weight losses or gains and address with recommendation for the physicians to approve. The Interim DON, Unit Managers and/or designee will also review weights on a weekly and monthly basis to ensure appropriate notification has been made to the physician and family for any significant weight loss or gain and any new orders from the physician. The Registered Dietitian will review care plan, any ordered supplements, adaptive equipment, labs, snacks as she is reviewing those with noted weight loss or gain for appropriate nutritional needs. The IDT will meet and review the significant weight losses and weight gains and review weekly weight losses/gains 2% and monthly weight losses/gains 5%.</p> <p>The RD will review all residents receiving tube feeding on no less than a monthly basis regardless of weight loss or gain, and weekly if 2 % weight loss/gain and monthly for 5% weight loss/gain.</p>		

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F 325	<p>Continued From page 17</p> <p>hanging on a tube-feeding pump. A bag that was marked as water was also hanging and was dated 07/31/14. There were 100 cc in the water bag. The tube-feeding pump indicated the feeding was set to infuse at 60 cc an hour with 125 cc of water every 4 hours.</p> <p>Observation of Resident #1 at 11:40 AM revealed 1500 cc remained in the Jevity tube-feeding bottle, but there were 1000 cc of water in the bag. The tube-feeding pump was set to infuse at 60 cc per hour and a green light was on indicating there were no problems. Observation of Resident #1 at 12:30 PM, 2:00 PM, and 3:10 PM on 07/31/14 revealed the tube-feeding bottle remained at 1500 cc, even though the tube-feeding pump indicated 80 cc of tube-feeding was infusing per hour. In addition, at 3:10 PM, 925 cc of water remained in the bag (75 cc infused in approximately three and one-half hours).</p> <p>Interview with LPN #3 on 08/01/14 at 3:45 PM revealed Resident #1's tube-feeding pump was cleared (reset to zero) at the beginning of the shift on 07/31/14 (approximately 6:30 AM), and was routinely cleared three times per day at shift change. LPN #3 stated staff started a new bottle of tube-feeding sometime after staff cleared the pump on 07/31/14. LPN #3 further stated during the day shift on 07/31/14, Resident #1 received 471 cc of tube-feeding and 250 cc of water. She stated she documented the tube-feeding and water intake under "treatment" on the computer based on feeding pump readings. LPN #3 was not aware of any problems with the tube-feeding pumps or with tube-feeding infusing as ordered.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted Resident #2 on</p>	F 325	<p>All Licensed Staff were educated and competencies were observed with Tube feeding procedures, and Medication Administration this was completed on 8/8/14. On 7/26/14 through 8/6/14 daily medication administration audits were completed with 3 nurses. No issues noted.</p> <p>4. The Interim DON and Unit Mangers will review weights on a weekly basis to ensure weight losses and gains are being addressed and appropriate notification is made to the physicians and families. The IDT will review for appropriate interventions and recommendation from Registered Dietitian and ensure care plans are reflective of any new interventions. The DON and/or IDT will report any trends or issues noted to the Quality Assurance Performance Improvement Committee for any further recommendations on a monthly or as needed basis for further recommendations. Substantial compliance will be achieved by 8/31/14.</p>		

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

PRINTED: 08/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/06/2014
NAME OF PROVIDER OR SUPPLIER DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
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F 325	<p>Continued From page 18</p> <p>03/09/12 with diagnoses including Dysphagia, Dementia, Psychosis, and Alzheimer's disease. Review of Resident #2's most recent Quarterly Minimum Data Set (MDS) assessment dated 07/25/14 revealed the facility assessed that Resident #2 was cognitively impaired and was interviewable.</p> <p>Review of Resident #2's comprehensive care plan dated 04/03/14 revealed Resident #2 required tube-feedings. The facility's intervention was to administer tube-feedings and water flushes per physician orders.</p> <p>A review of Resident #2's Physician's Orders for July 2014 revealed Resident #2 required tube-feeding at 55 cc per hour for 22 hours every day via feeding pump.</p> <p>Review of Resident #2's electronic Medication Administration Record (eMAR) revealed Resident #2 received 784 cc of tube-feeding on 07/31/14.</p> <p>However, observation of Resident #2 on 07/31/14 at 10:25 AM, 11:25 AM, 12:25 PM, 2:03 PM, and 3:05 PM revealed the tube-feeding bottle remained at 1500 cc and no tube-feeding infused during the four hour and forty minute period. Observation at 10:25 AM on 07/31/14 revealed the tube-feeding bottle was started on 07/31/14 at 9:45 AM and contained 1500 cc of tube-feeding. The tube-feeding pump was set to administer 55 cc per hour. Further observations of Resident #2 on 07/31/14 at 11:25 AM, 12:25 PM, 2:03 PM, and 3:05 PM revealed the tube-feeding bottle continued to have 1500 cc of feeding in the bottle, even though the pump was set to administer 55 cc of feeding per hour.</p>	F 325			

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F 325	<p>Continued From page 19</p> <p>Interview with LPN #3 on 08/01/14 at 3:45 PM revealed Resident #2 received 310 cc of water and 428 cc of tube-feeding during the day shift on 07/31/14, according to the resident's tube-feeding pump.</p> <p>Interview with the Unit Manager (UM)/acting Director of Nursing (DON) on 07/31/14 at 5:15 PM revealed staff documented resident tube-feeding intake on eMARs and the UMs reviewed the documentation daily at the end of the shift (around 5:00 PM). According to the UM/acting DON, if documentation revealed that tube-feeding was not administered as ordered, the UMs talked with the nurses to see if the pumps were turned off for any reason. The UM/acting DON stated nurses should monitor to ensure tube-feeding pumps were on and working properly. The UM/acting DON stated she and the Unit Managers did not monitor to ensure tube-feeding pumps were working appropriately. The UM/acting DON further stated tube-feeding pumps were not easy to use at first, but the nurses were having less trouble with the alarms going off on the pumps.</p>	F 325			