

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2010
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NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Preparation and 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. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.	
F 157 SS=D	<p>An annual survey was conducted on 08/30/10 through 09/02/10 to determine compliance with Federal certification requirements. The facility was found not to meet Federal requirements for recertification with the highest S & S being a "D".</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>F157</p> <p>1) Physician was notified of resident #8's significant change in condition at 10:00 AM on 5/7/10. Effective 9/3/10, physician and family will be notified immediately of a significant change. Licensed staff were in-serviced immediately upon their next scheduled shift as well as at a scheduled in-service on 9/8/10 related to the "Change of Condition" policy.</p> <p>2) All resident's with a significant change have the potential to be affected by this practice.</p> <p>3) All licensed staff was in-serviced on 10/13/10 by the DON.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Adm.* (X5) DATE: *10/15/10*

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	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to immediately consult with the physician when there was a significant change in condition, which resulted in an injury for one resident (#8), in the selected sample of 18. Findings include: A record review revealed Resident #8 was admitted to the facility on 12/20/08 with diagnoses to include Osteoarthritis, Alzheimer's disease, Dementia without behaviors, Metastase, Fatigue, Fractured Humerus-Closed and Difficulty Walking. A review of the significant change Minimum Data Set (MDS), dated 05/07/10, revealed the resident was not interviewable due to his/her cognitive status. He/she required extensive assistance of two staff with bed mobility and transfer. A review of the nurse's note, dated 05/06/10 at 8:10 PM, revealed Resident #8 was found lying beside his/her bed on the floor with no apparent injuries noted. Further review of the nurse's note, on 05/07/10 at 4:45 AM, revealed discomfort was noted when Resident #8's legs and hip area were palpated; however, no swelling, bruising, or broken areas were noted at this time. According to documentation in the nurse's note, on 05/07/10 at 5:20 AM, guarding of the resident's right lower extremity and right hip with edema were noted. Additionally, a review of the nurse's note revealed pain medication was administered to Resident #8 at this time.	F 157	regarding the "Change of Condition" policy (see attached) and more often as deemed necessary. The DON in-serviced staff to notify the physician immediately of any change of condition. 4) To ensure the continuation of proper physician notification, Amanda Ballard, RN (or other administrative nurse in her absence) will review charts on resident's with identified significant changes to ensure that the physician was notified. Results from these checks will be reviewed for monthly for two months by the QA team. This time frame is subject change dependent on the findings of the QA program. All licensed staff were in-serviced on 10/13/10 by the DON regarding the "Change of Condition" policy (see attached) and more often as deemed necessary. F280 1) The care plan has been reviewed and changed for resident #4 related to falls and potential	F157 10/17/10	

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F 157	<p>Continued From page 2</p> <p>According to the nurses' notes and physician's orders, the resident's physician was not notified of the significant change in condition until 05/07/10 at 10:00 AM, at which time an order was received for an x-ray of the right hip, pelvis and leg. At 10:30 AM, an x-ray was completed at the facility, which revealed comminuted intertrochanteric fracture of the right femur. The resident was sent by ambulance to a local hospital, where he/she was admitted. A review of the Discharge Summary from the hospital, revealed the resident had surgery to repair the right hip on 05/08/10 and returned to the facility on 05/12/10.</p> <p>An interview with Registered Nurse (RN) #2 on 09/01/10 at 2:15 PM, revealed Resident #8 was found lying on the floor on 05/08/10 at 8:10 PM with no apparent injury. She further revealed, the resident complained of general pain "all over" after the fall.</p> <p>An interview with RN #3 on 09/02/10 at 10:05 AM, revealed Resident #8 was not experiencing pain at midnight, but was guarding his/her right hip later in the early morning hours on 05/07/10. She further revealed Tylenol was administered around 8:00 AM because of the resident's facial expressions. The RN stated she rated the resident's pain as a "7" on a pain scale of "0 to 10", "10" being the worst. She stated, "I did not feel the need to call the physician at 5:20 AM on 05/07/10." She further revealed the physician should have been notified with a change in condition.</p> <p>An interview with the Director of Nursing (DON), on 09/02/10 at 8:45 AM, revealed she was not aware whether or not Resident #8 had a change in condition on 05/07/10.</p>	F 157	<p>accident hazards (recliners) on 9/1/10.</p> <p>2) Any resident with the potential to fall will have individualized care plans to address falls. All current residents at risk for falls care plans have been reviewed and updated to reflect individualized care plans to address falls.</p> <p>3) To ensure that the deficient practice does not reoccur, the following has been implemented:</p> <ul style="list-style-type: none"> - Any resident with the potential to fall will have individualized care plans to address falls. - This facility will assess admissions and readmissions with or without known histories of falls. This facility will properly identify those who are at increased risks for falls and initiate further fall prevention measures. - All licensed staff have been in-serviced regarding the "Fall Prevention" policy (see attached). <p>4) Care plans addressing residents with the potential for falls will be</p>	

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F 167	Continued From page 3 An interview with the on-call physician, on 09/02/10 at 9:30 AM, revealed she expected to be notified of a resident's change in condition. She stated she was not notified of a significant change in Resident #8's condition until 05/07/10 at 10:00 AM. A review of the facility's "Change in Resident's Condition or Status" policy, undated, revealed "The facility shall promptly notify the resident, his or her attending physician, and family/responsible party of changes in the resident's condition and/or status:"	F 157	revised and updated quarterly, annually, with significant changes and as needed. Falls will be assessed by the fall committee under the direction of Sue Jackson, RN. Care plans related to falls will be reviewed and revised by the fall committee as needed or initiated in the instance of a first fall. All resident's with a current fall care plan have been reviewed by Sue Jackson, RN by 10/9/10. Results and outcomes related to fall care plans and approaches will be reported to the QA team monthly for two months, then quarterly.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	<u>E282</u> 1) Physician was notified of resident #8's significant change in condition at 10:00 AM on 5/7/10. This facility has ensured that resident #8's care is provided in accordance with the written plan of care, specifically related to physician notification. This was accomplished by in-servicing licensed staff by the DON on 9/8/10 and 10/13/10.	<u>F280</u> 10/17/10	

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F 280	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to ensure the care plan was reviewed and revised by a team of qualified persons for one resident (#4) in the selected sample of 16, related to falls from a recliner. Findings include:</p> <p>A record review revealed Resident #4 was admitted on 02/05/09 with diagnoses to include Syncope and Collapse, Hypertension, Dementia with behaviors, Psychosis, Alzheimer's Disease and Atrial Fibrillation.</p> <p>A review of the annual Minimum Data Set (MDS), dated 01/20/10, revealed Resident #4 was not interviewable due to being cognitively impaired. The resident required extensive assistance of two staff members for bed mobility and transfer.</p> <p>Observations of Resident #4 on 08/31/10 at 10:26 AM, 11:50 AM, 12:20 PM, and 3:35 PM, revealed the resident was sitting in a reclined position in a recliner in his/her room.</p> <p>A review of the nurses' notes, dated 05/25/10 at 11:10 AM, 07/10/10 at 6:16 PM, and 07/11/10 at 10:20 AM, revealed Resident #4 was found sitting on the floor in front of his/her recliner. Additionally, a review of the nurse's note on 07/10/10, revealed the resident stated he/she "slid out of the recliner."</p> <p>A review of Resident #4's "Falls" care plan, dated 01/20/10, revealed there were no approaches addressing the resident's falls from the recliner on 05/25/10, 07/10/10 or 07/11/10.</p>	F 280	<p>2) On 9/2/10, the DON reviewed charts of resident's with significant changes with a focus on physician notification. Licensed staff were in-serviced regarding following residents plan of care specifically related to physician immediate notification at scheduled in-services on 9/8/10 and 10/13/10 by the DON. (See #4 for audits and results)</p> <p>3) To ensure that the deficient practice does not reoccur, the following has been implemented:</p> <ul style="list-style-type: none"> - Licensed staff were in-serviced on 9/8/10 and 10/13/10 by the DON related following care plans specifically and physician immediate notification. <p>4) Amanda Ballard, RN (or other administrative nurse in her absence) will review charts for three resident's a week with identified significant changes to ensure that the written plan of care was followed with a focus specifically on physician notification. This will be done for two months. Results from these checks will be reviewed monthly</p>		

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F 280	Continued From page 5 An interview with Registered Nurse (RN) #4 on 08/31/10 at 10:55 AM, revealed the resident would "wiggled out" of the recliner, but did not attempt to get up without assistance. She stated the resident's recliner should have been addressed in the care plan, and an assessment should have been completed for Resident #4's recliner related to falls and safety. "We were checking on him/her every hour after the falls. I thought that would cover the recliner assessment, even though, it was not addressed on the care plan." The facility's policy/procedure "Falls Prevention" dated 02/09/05, revealed "Plan of care requirements include if a current care plan included potential for injury related to falls, add additional interventions for possible preventions of falls. List appropriate interventions for resolution of identified conditions without complications."	F 280	for two months by the QA team. This time frame is subject to change dependent on the findings of the QA program. Licensed staff were in-serviced on 9/8/10 and 10/13/10 by the DON related following care plans specifically and physician notification.	F282 10/17/10
F 282 SS-D	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 interviews and record review, it was determined the facility failed to provide services in accordance with each resident's written plan of care for one resident (#8), in the selected sample of 10, related to a fall from the bed sustained on 05/09/10. Findings include:	F 282	<u>F309</u> 1) The facility will thoroughly assess residents for evidence of pain and follow approved practice to attempt to minimize the occurrence/intensity of pain for residents. Resident #8 care plan has been reviewed to meet the above policy statement. 2) All resident's have the potential to be affected by pain and have individualized care plans to address pain. These care plans have been reviewed. Ongoing pain assessment's will be completed using the Wong-Baker pain rating scale for all resident's. 3) Licensed staff were in-serviced upon their next scheduled shift as well as at a scheduled in-service by	

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F 282	<p>Continued From page 6</p> <p>A record review revealed Resident #8 was admitted to the facility on 12/20/06 with diagnoses to include Osteoarthritis, Alzheimer's disease, Dementia without Behaviors, Malaise, Fatigue, Fractured Humerus-Closed and Difficulty Walking.</p> <p>A review of the significant change Minimum Data Set (MDS), dated 05/07/10, revealed the resident was not interviewable due to his/her cognitive status. He/she required extensive assistance of two staff with bed mobility and transfer.</p> <p>A review of the care plan for "Falls", dated 05/06/10, revealed Resident #8 sustained an unwitnessed fall from his/her bed on 05/06/10. Additionally, the care plan revealed to report the fall to the physician.</p> <p>An interview with Registered Nurse (RN) #2 on 09/01/10 at 2:15 PM, revealed after the fall which occurred on 05/06/10 at 6:10 PM, a message was left for a return call with the physician's answering service at 8:10 PM. She further revealed the physician never returned the call on her shift, which ended at 11:00 PM; however, the information was reported to the nurse on the next shift. RN #2 stated, "If the physician had returned my call that evening, I would have documented it."</p> <p>An interview with RN #3 on 09/02/10 at 10:05 AM, revealed she could not recall if RN #2 reported information to her about contacting the answering service or about no return call from the physician. She stated, "I did not receive a return call from the physician on my shift."</p> <p>An interview with the Director of Nursing (DON)</p>	F 282	<p>the DON on 9/8/10 regarding our "Pain Management" policy (see attached) specific to interpretation and implementation. Licensed staff will be in-serviced during the next two monthly in-services. This facility utilizes the Wong-Baker scale. To keep this practice from recurring, pain management has been incorporated in the QA program (see #4).</p> <p>4) All resident's have the potential to be affected by pain and have individualized care plans to address pain. Implementation of the pain management program has been incorporated into the QA program. Four charts a week will be randomly audited to ensure that a care plan has been implemented for pain management. This will be conducted by Diana Rodgers, RN. Results from the audit will be brought to the QA program monthly for two months. Audits will be extended as necessary dependent on QA findings.</p> <p><u>F323</u> 1) Resident #4 was assessed for fall safety in the recliner on 9/1/10.</p>	<p>F309 10/11/10</p>
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F 282	Continued From page 7 on 09/02/10 at 8:45 AM, revealed a follow-up from the physician after placing a call to the answering service was expected to be documented in the resident's record. A review of the facility's policy/procedure, "Care Plans", undated, revealed "The facility shall promptly notify the resident, his or her attending physician, and family/responsible party of changes in the resident's condition and/or status." 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 282	2) All current resident's having the potential for falls and risk/accident hazards (recliners) will be assessed in the facility. Resident's will also be assessed upon admission and quarterly or in the event of a fall for fall risk and accident hazards (recliners) in order to avoid injury and to maintain maximum physical functioning as much as possible. 3) Facility system changes utilizing the Assistive Device Assessment in conjunction with the Fall Assessment will ensure resident's will be identified and assessed upon admission and quarterly for risks for falls and potential accident hazards related to assistive devices. The assessments will be completed jointly by nursing and the therapy staff. If necessary, individualized care plans will be implemented based upon the assessment findings. Care plans are put in place immediately by licensed staff in the event of a fall. The post-fall assessment is completed after any fall and, along with the event report, forwarded to the Fall	
F 309 SS=D	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 interviews and record review, it was determined the facility failed to provide 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, for one resident (#8), in the selected sample of 16. Resident #8 sustained an unwitnessed fall from his/her bed on 05/08/10 at 8:10 PM and initially complained of pain. Pain medication was not administered to the resident until 05/07/10 at 5:00 AM and the physician was not notified of the change in condition until 05/07/10 at 10:00 AM. Findings include:	F 309		

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F 309	<p>Continued From page 8</p> <p>A record review revealed Resident #8 was admitted to the facility on 12/20/08 with diagnoses to include Osteoarthritis, Alzheimer's disease, Dementia without Behaviors, Malaise, Fatigue, Fractured Humerus-Closed and Difficulty Walking.</p> <p>A review of the significant change Minimum Data Set (MDS), dated 05/07/10, revealed the resident was not interviewable due to his/her cognitive status. He/she required extensive assistance of two staff with bed mobility and transfer.</p> <p>An interview with Registered Nurse (RN) #2 on 09/01/10 at 2:15 PM, and review of the nurse's note, revealed Resident #8 was found lying on the floor beside his/her bed on 05/06/10 at 8:10 PM, complaining of general pain all over. She further revealed during a pain assessment of Resident #8, she evaluated him/her for grimacing and complaints of pain when touched. RN #2 stated Resident #8 was able to express verbally when he/she was in pain. She stated, "I did not administer the resident pain medication; it would have been charted on the Medication Administration Record (MAR) if I had."</p> <p>An interview with State Registered Nurse Aide (SRNA) #1 on 09/02/10 at 9:16 AM, revealed she worked on 05/06/10 until 11:00 PM. She stated, while Resident #8 was being repositioned after the fall, she could hear the resident loudly saying "ouch" while the SRNA stood in the hallway outside the resident's room. She stated, "I could tell Resident #8 was in pain because you could hear it in his/her tone of voice."</p> <p>An interview with SRNA #2 on 09/02/10 at 10:40 AM, revealed Resident #8 was complaining about</p>	F 309	<p>Assessment Committee for review at regular meetings. Corrective action is implemented by licensed staff, if possible, to prevent recurrence of identified causative factors. A standardized initial fall assessment and post-fall assessment is used to accurately document possible causative factors, revision of interventions to prevent further occurrence, and any medical treatment required. The fall committee evaluates the care plan implemented for the resident after a fall, making any changes deemed necessary to the approaches. The fall committee consists of therapy, activities, nursing, social services and dietary.</p> <p>4) To ensure compliance with completing admission and quarterly assessments regarding risks for falls and potential accident hazards related to assistive devices, Sue Jackson, RN will review three charts weekly to include admissions and quarterly assessments. Results will be included in the next two monthly QA meetings. Audits will be</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2010
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NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
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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 309	<p>Continued From page 9</p> <p>hip pain before being returned to bed after the fall. Resident #8 was asked by the charge nurse if he/she was hurting after the fall and the resident replied, "Yes, my leg."</p> <p>A review of the MAR, dated May, 2010, revealed Resident #8 received Acetaminophan (pain reliever) 325 milligrams (mg), two tablets by mouth (PO) on 05/07/10 at 5:00 AM for complaints of leg and hip pain. The MAR further revealed Resident #8's pain was rated a "7" on a pain scale of "0 to 10." There was no evidence of any results of the medication effectiveness on the MAR.</p> <p>An interview with RN #3 on 09/02/10 at 10:05 AM, revealed Resident #8 did not experience any pain at midnight, but was guarding his/her right hip later in the early morning hours on 05/07/10. She stated Tylenol was administered around 5:00 AM because of the resident's facial expressions. The RN stated she rated the resident's pain as a "7" on a pain scale of "0" to "10", "10" being the worst. She stated, "I failed to chart the effectiveness of the medication on the MAR. I did not feel the need to call the physician at 5:20 AM on 05/07/10."</p> <p>A review of nurses' notes and physician's orders revealed the physician was notified of a significant change in the resident's condition and an order was received on 05/07/10 at 10:00 AM for an x-ray, which was completed on 05/07/10 at 10:30 AM and showed a fracture of the right femur. The resident was sent by ambulance to a local hospital, where he/she was admitted. A review of a Discharge Summary from a local hospital, revealed the resident had surgery to repair the right hip on 05/08/10 for a fractured right hip, from</p>	F 309	<p>extended as necessary dependent on QA findings.</p> <p><u>F505</u></p> <p>1) Lab work was repeated on 8/31/10 with the results being faxed and called to the nurse practitioner, with no new orders received. Lab director was notified by the Administrator informing them of the interruption of service for the interface providing lab results to the physicians. The new policy was established and is attached.</p> <p>2) All residents have the potential to be affected when lab values are not reported to the physician promptly.</p> <p>3) Lab director was notified by the Administrator informing them of the interruption in service for the interface providing lab results. The new Relay Health Downtime Notification policy (see attached) was established. In addition to the aforementioned policy, Superior Care Home will continue to follow Superior Care's Clinical Lab policy(see attached).</p>	<p><u>F323</u> 10/17/10</p>
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NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
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F 309	Continued From page 10 a fall at the nursing facility on 05/08/10. The resident returned to the facility on 05/12/10. The facility's policy/procedure "Pain Management", undated, revealed "The facility will thoroughly assess residents for evidence of pain and follow approved practice to attempt to minimize the occurrence/intensity of pain for residents."	F 309	Administrative nursing and Administration have been made aware of the updated Relay Health Downtime Notification policy. Licensed staff have been in-serviced on 10/13/10 by the DON regarding the Clinical Lab policy and will continue for the next two monthly in-services.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to ensure the resident's environment remains as free of accident hazards as possible for one resident (#4) in the selected sample of 16, related to falls which occurred from the use of a recliner without being properly assessed. Findings include: A record review revealed Resident #4 was admitted on 02/05/09 with diagnoses to include Syncope and Collapse, Hypertension, Dementia with behaviors, Psychosis, Alzheimer's Disease and Atrial Fibrillation. A review of the annual Minimum Data Set (MDS),	F 323	4) Amanda Ballard, RN, will randomly audit three charts a week to ensure that labs have been followed thru on according to the facility Clinical Lab Policy. The results of this review will then be reported to the QA program weekly for the next thirty days to ensure appropriate follow thru. Audits will be extended as necessary dependent on QA findings.	F505 10/17/10

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F 323	<p>Continued From page 11</p> <p>dated 01/20/10, revealed Resident #4 was not interviewable due to being cognitively impaired. The resident required extensive assistance of two staff members for bed mobility and transfer.</p> <p>A review of the nurses' notes, dated 06/25/10 at 11:10 AM, 07/10/10 at 8:15 PM, and 07/11/10 at 10:20 AM, revealed Resident #4 was sitting on the floor in front of his/her recliner with no apparent injuries noted.</p> <p>Observations of Resident #4 on 08/31/10 at 10:25 AM, 11:50 AM, 12:20 PM, and 3:35 PM, revealed the resident was sitting in a reclined position in a recliner in his/her room.</p> <p>An interview with Registered Nurse (RN) #5 on 08/31/10 at 10:36 AM, revealed residents at risk for falls were assessed prior to a resident's admission to the facility by the administrative staff and upon admission by the nursing staff. She further revealed any fall that occurred over the last 24 hours was addressed in the morning meeting. If the fall occurred on the weekend, it would be addressed on the following Monday. She stated, "I do not know if Resident #4 was assessed for the recliner in his/her room, but RN #4 would have been responsible for the assessment."</p> <p>An interview with RN #4, on 08/31/10 at 10:55 AM, revealed anytime a resident fell, the incident was addressed in the morning meeting. She stated she had placed Resident #4 on an hourly fall monitoring program for thirty days each time he/she had more than one fall in a thirty-day period. She revealed an assessment would have been completed on the resident for the use of the recliner if a problem had been identified. She</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
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F 323	Continued From page 12 stated, "I should have completed an assessment, but probably did not." A review of Resident #4's care plan for "Falls", dated 01/20/10, revealed no approaches to address the resident's falls from the recliner on 05/25/10, 07/10/10 or 07/11/10. A review of the "Post-Fall Assessments," dated 05/25/10 at 11:10 AM, 07/10/10 at 6:15 PM, and 07/11/10 at 10:20 AM, revealed there were no immediate actions taken to prevent Resident #4 from further falls from the recliner. A review of the facility's policy/procedure "Falls Prevention", undated, revealed "A standardized initial fall assessment and post-fall assessment is used to accurately document possible causative factors, revision of interventions to prevent further occurrence, and any medical treatment required."	F 323		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure laboratory values provided to the facility, were called and/or faxed to the physician in a timely manner for one resident (#2). In the selected sample of 16, related to the results of a Prothrombin Time (Pro-Time) and International Normalized Ratio (INR). Findings include: Resident #2 was admitted to the facility on	F 505		

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F 605	<p>Continued From page 13</p> <p>03/04/10 with diagnoses to include Chronic Systolic Heart Failure, Coumadin Therapy, Ischemic Heart Disease, and history of hip and humerus fracture.</p> <p>A review of Resident #2's current physician orders, dated 08/27/10, revealed an order for the Pro-Time to be drawn every week and to give Coumadin 2.5 milligrams every day by mouth.</p> <p>A review of the clinical lab report, dated 08/25/10, revealed the resident's Pro-Time result was 36.2 and the INR was 3.70. A review of the clinical record revealed neither the Physician nor the Nurse Practitioner (NP) were notified of the resident's lab result from that date. Another physician's order was received, on 08/31/10, for a Pro-Time and INR to be drawn. The results of the Pro-Time 15.4 and INR 1.52, were faxed and called to the NP, with no new orders received.</p> <p>An interview with Registered Nurse (RN) #1, on 08/10/10 at 8:30 AM, revealed routine laboratory (lab) services were provided daily with the largest lab day being on Wednesday. RN #1 stated when lab results were completed, they were faxed to the facility from the local hospital lab. The lab results were then faxed to the physician's office. RN #1 stated when there was a "panic value", then the lab results were immediately called to the physician's office or to the NP. RN #1 further stated that all labs, except for lab results for two specific physicians were faxed. RN #1 stated, "Those labs were reviewed on the interface (hospital computer program) from the hospital, so we do not contact those physicians, since they review the lab results on the computer".</p>	F 505		
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NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001		
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F 505	<p>Continued From page 14</p> <p>Interviews with the Director of Nursing (DON), on 09/01/10 at 10:48 AM and at 3:20 PM, revealed the interface between the two specific physicians, as well as the NP, had been down since "last week sometime". The DON further stated the facility was not aware of the system being down. The DON revealed the facility received all copies of labs by fax from the lab, regardless of whether the interface was down or not. The DON stated when the labs were completed, the facility received the labs by fax. The labs were then faxed to the resident's physician. The staff then initialed and dated the lab requisition results, after the results were faxed or called to the physician's office. The physician's office then either called with a new order or faxed back on the lab results sent to the physician's office. The DON further stated, "We are responsible for the labs and I know that. It just happened."</p> <p>An interview with the NP, on 09/01/10 at 3:05 PM, revealed she was not aware of the interface "being down" the previous week. The NP stated, "Things are just out of the 'norm' this week. When the interface is working, I can see all of the lab results". The NP further stated the facility would have had no way to know to call her with any result, "because the facility did not know the system was down and neither did I".</p> <p>A review of the facility's policy entitled Clinical Lab Policy, undated, revealed it was the policy of the facility to notify the physician or other healthcare providers of lab values. The policy further stated that a licensed nurse would review the lab results and the results were to be faxed or called to the providers. The policy further stated in the event of a critical value, the lab would notify the nurse and the nurse would in turn call the result to the</p>	F 505		

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F 505	Continued From page 15 provider to notify the provider of the critical result.	F 505			

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 09/02/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

9/29/10

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.

[Handwritten Signature]