

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

PRINTED: 08/28/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/16/2013
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An abbreviated survey (KY #20516 and KY #20518) was conducted on 08/12/13 through 08/16/13 to determine the facility's compliance with Federal requirements. KY #20516 was substantiated with deficiencies cited with the highest scope and severity of a "D". KY #20518 was unsubstantiated with no deficiencies cited.	F 000	<p><b>DISCLAIMER: This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Dawson Pointe, d/b/a Dawson Springs Health and Rehabilitation Center, agrees with the allegations and citations listed on the pages of the Statement of Deficiencies. Dawson Springs Health and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates stated. Dawson Springs Health and Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction.</b></p> <p>F157 Res #1 <b>1. Corrective Action</b></p> <p>RN re-educated on the facility's Anti-coagulant Policy and Procedure by the DON on 7-26-13 which included change in condition and the contact of physician for any signs/symptoms of blood loss prior to the administration of an anticoagulant.</p>	
F 157 SS=D	<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>	F 157		

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

TITLE

(X8) DATE

*[Handwritten Signature]* *[Handwritten Signature]* 9-5-13

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 facility must record and periodically update 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 and record review it was determined the facility failed to notify the physician when there was a need to alter treatment for one (1) resident (#1), in the selected sample of three (3) residents. Resident #1 was on Coumadin (anti-coagulant) therapy and presented with blood tinged urine after a catheter change on 07/21/13. The physician was not contacted prior to the administration of Coumadin. The resident had a change in mental status. Resident #1 was admitted to the hospital with hematuria secondary to indwelling catheter and urethral stricture.</p> <p>The findings include:</p> <p>A review of the Anticoagulant Policy And Procedure dated 03/12/13 revealed #4 Notify the attending physician or physician on call of resident's status and of any sign/symptoms of blood loss</p> <p>A record review revealed Resident #1 was admitted to the facility on 05/23/13 with diagnosis to include Open Fracture Unspec Intracapsular Section neck Femur, Aftercare for Healing Traumatic Fracture of Hip, Unspecified Urethral Stricture, Other Specified Disorder of the Penis, Urinary Tract Infection, Unspecified Disorder Of The Kidney and Ureter, End Stage Renal Disease, Unspecified Anemia, Unspecified Urinary Retention, Malignant Neoplasm Of</p>	F 157	<p>RN received counseling on 7-26-13 from the DON related to not following facility policy and procedure.</p> <p><b>2. ID of Others at Risk</b></p> <p>All residents considered to be at risk due to Coumadin therapy were reviewed by the DON and/or Administrative QA/Compliance Nurse on 7-23-13 with no other resident identified as having any adversity regarding the administration of the medication.</p> <p><b>3. Prevention</b></p> <p>All licensed direct care staff were in-serviced on 7-23 thru 7-26-13 prior to their next duty of the administration of medication by the DON regarding following the established protocols of administering an anti-coagulant medication.</p> <p>Inservice provided to licensed direct care staff on Physician Notification and Change in Condition, assessment and following the comprehensive care plan on 7-23 thru 7-26-13 by the DON.</p> <p>A mandatory meeting for all licensed direct care staff to review again the Anti-coagulant Policy and Procedure including the physician notification regarding any sign/symptoms of blood loss was held 9-5-13 by the DON.</p>	

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F 157	<p>Continued From page 2</p> <p>Cecum, Congestive Heart Failure and Senile Dementia. A review of the significant change Minimum Data Set (MDS) assessment, dated 07/11/13, revealed the facility assessed Resident #1's cognition as moderately impaired.</p> <p>A review of the physician order, dated 07/15/13, revealed staff should administer Coumadin three (3) milligrams (mg.) by mouth (PO) every day.</p> <p>A review of the nurse notes, dated 07/21/13 at 3:45 AM, revealed Resident #1's catheter was changed with blood tinged urine noted in the tubing.</p> <p>Interview with LPN #1, on 08/13/13 at 2:35 PM, revealed she was told in report from LPN #2 that Resident #1 had been pulling on the catheter, the catheter was changed and there was bloody urine return. The LPN stated she checked on Resident #1 after report and noted there was 200 cc's dark brown urine.</p> <p>Interview with Registered Nurse #1, on 08/15/13 at 9:55 AM, revealed she was told in report Resident #1 had pulled on the catheter and had some bleeding and the catheter was changed. The RN stated LPN #1 said when she first checked the urine there appeared to be blood and clots. The RN revealed at 11:00 AM, the urine was pink in color, the resident was alert and oriented and she administered Coumadin. The RN stated because the urine was pink in color she thought the bleeding had slowed and went ahead and administered the Coumadin without notifying the physician.</p> <p>A review of the Medication Administration Record dated 07/13 revealed Coumadin 3 mg</p>	F 157	<p>4. Monitoring</p> <p>CQI Tool, Coumadin Interaction Tool, was initiated on 9-3-13 by the Administrative Nurses for a weekly review of the administration of Coumadin x 1 month, with follow ups as recommended by the QA Committee. Review reports are provided to the DON who reports this information to the monthly meeting of the Quality Assurance (QA) Committee. Any problems identified are addressed immediately and a report provided to the DON and QA Committee of action taken.</p> <p>5. Date Corrected:</p>	9-6-13

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F 157	Continued From page 3 administered on 07/21/13 by mouth at 11:00 AM.  A review of a nurse's note, dated 07/21/13 at 1:00 PM, revealed the resident continued to have blood tinged urine in the urinary tubing. The resident's pupils were fixed and were staring upward. The resident was confused when asked questions. The physician was called with new orders received to send to the hospital. Interview with RN #1, on 08/15/13 at 9:55 AM, revealed the CNA came and told her the resident wasn't acting right. The RN revealed she assessed the resident immediately and the resident had a change in mental status. The RN contacted LPN #1 and the resident was sent out to the hospital.  Interview the Director of Nursing, on 08/14/13 at 5:50 PM, revealed she would have checked with the physician before giving Coumadin if the resident had some bleeding.  Interview with Resident #1's attending physician, on 08/14/13 at 4:10 PM, revealed he was notified of the resident's change in behavior, and was told the resident had pulled on the catheter and had some bleeding. The physician revealed the nurse should have called him prior to the administration of the Coumadin due to the blood in the urine. The physician stated he would have withheld the Coumadin and checked the residents International Normalized Ratio (INR).  A review of the discharge summary, dated 07/24/13, revealed a diagnoses of Hematuria secondary to indwelling catheter and urethral stricture, Anemia secondary to acute blood loss and Coumadin led to an increase in INR.	F 157		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	<p>Continued From page 4 HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to 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 for one (1) resident (#1), in the selected sample of three (3) residents, related to administering Coumadin (anti-coagulant) without notifying the physician when blood was noted in the resident's urine. Resident #1 was admitted to the hospital with hematuria secondary to indwelling catheter and urethral stricture.</p> <p>The findings include: A review of the Anticoagulant Policy And Procedure dated 03/12/13 revealed #4 Notify the attending physician or physician on call of resident's status and of any sign/symptoms of blood loss A record review revealed Resident #1 was admitted to the facility on 05/23/13 with diagnosis to include Open Fracture Unspec Intracapsular</p>	F 309	<p>F309</p> <p>Res #1</p> <p><b>1. Corrective Action</b></p> <p>RN re-educated on the facility's Anti-coagulant Policy and Procedure by the DON on 7-26-13 which included change in condition and the contact of physician for any signs/symptoms of blood loss prior to the administration of an anticoagulant.</p> <p>RN received counseling on 7-26-13 from the DON related to not following facility policy and procedure.</p> <p><b>2. ID of Others at Risk</b></p> <p>All residents considered to be at risk due to Coumadin therapy were reviewed by the DON and/or Administrative QA/Compliance Nurse on 7-23-13 with no other resident identified as having any adversity regarding the administration of the medication.</p> <p><b>3. Prevention</b></p> <p>All licensed direct care staff were in-serviced on 7-23 thru 7-26-13 prior to their next duty of the administration of medication by the DON regarding following the established protocols of administering an anti-coagulant medication.</p>		

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F 309	<p>Continued From page 5</p> <p>Section neck Femur, Aftercare for Healing Traumatic Fracture of Hip, Unspecified Urethral Stricture, Other Specified Disorder of the Penis, Urinary Tract Infection, Unspecified Disorder of The Kidney and Ureter, End Stage Renal Disease, Unspecified Anemia, Unspecified Urinary Retention, Malignant Neoplasm Of Cecum, Congestive Heart Failure and Senile Dementia. A review of the significant change Minimum Data Set (MDS) assessment, dated 07/11/13, revealed the facility assessed Resident #1's cognition as moderately impaired.</p> <p>A review of the Comprehensive Care Plan for at risk for bleeding related to use of Aspirin and Coumadin, dated 07/18/13, revealed a goal to be free of signs and symptoms of bleeding through next review and an intervention to monitor for signs and symptoms of bleeding and notify the physician of any problems.</p> <p>A review of the physician order, dated 07/15/13, revealed staff should administer Coumadin (anti-coagulant) three (3) milligrams (mg.) by mouth (PO) every day.</p> <p>A review of the nurse notes, dated 07/21/13 at 3:45 AM, revealed Resident #1's catheter was changed with blood tinged urine noted in the tubing.</p> <p>Interview with LPN #1, on 08/13/13 at 2:35 PM, revealed she was told in report from LPN #2 that Resident #1 had been pulling on the catheter, the catheter was changed and there was bloody urine return. The LPN stated she checked on Resident #1 after report and noted there was 200 cc's dark brown urine.</p>	F 309	<p>Inservice provided to licensed direct care staff on Physician Notification and Change in Condition, assessment and following the comprehensive care plan on 7-23 thru 7-26-13 by the DON.</p> <p>A mandatory meeting for all Licensed direct care staff to review again the Anti-coagulant Policy and Procedure including the physician notification regarding any sign/symptoms of blood loss was held 9-5-13 by the DON.</p> <p><b>4. Monitoring</b></p> <p>CQI Tool, Coumadin Interaction Tool, was initiated on 9-3-13 by the Administrative Nurses for a weekly review of the administration of Coumadin x 1 month, with follow ups as recommended by the QA Committee. Review reports are provided to the DON who reports this information to the monthly meeting of the Quality Assurance (QA) Committee. Any problems identified are addressed immediately and a report provided to the DON and QA Committee of action taken.</p> <p><b>5. Date Corrected:</b></p>	9-6-13	

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F 309	<p>Continued From page 6</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 08/13/13 at 1:45 PM, revealed she was assigned to Resident #1 and noted the urine in the catheter bag appeared to be brown in color. The CNA stated when she checked the resident at 10:00 AM there was 100 cc's of urine that was red/brown in color and she emptied the bag in the commode and noted the red coloring of the urine. The CNA revealed she reported this to LPN #1.</p> <p>Interview with Registered Nurse #1, on 08/15/13 at 9:55 AM, revealed she was told in report Resident #1 had pulled on the catheter and had some bleeding and the catheter was changed. The RN stated LPN #1 said when she first checked the urine there appeared to be blood and clots. The RN revealed at 11:00 AM, the urine was pink in color, the resident was alert and oriented and she administered Coumadin. The RN stated because the urine was pink in color she thought the bleeding had slowed and went ahead and administered the Coumadin without notifying the physician.</p> <p>A review of the Medication Administration Record dated 07/13 revealed Coumadin 3 mg administered on 07/21/13 by mouth at 11:00 AM.</p> <p>A review of a nurse's note, dated 07/21/13 at 1:00 PM, revealed the resident continued to have blood tinged urine in the urinary tubing. The resident's pupils were fixed and were staring upward. The resident was confused when asked questions. The physician was called with new orders received to send to the hospital. Interview with RN #1, on 08/15/13 at 9:55 AM, revealed the CNA came and told her the resident wasn't acting right. The RN revealed she assessed the resident immediately and the resident had a</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>change in mental status. The RN contacted LPN #1 and the resident was sent out to the hospital.</p> <p>Interview the Director of Nursing, on 08/14/13 at 5:50 PM, revealed she would have checked with the physician before giving Coumadin if the resident had some bleeding.</p> <p>Interview with the Administrator, on 08/15/13 at 2:10 PM, revealed the physician should have been notified of the blood in the urine prior to the administration of the Coumadin. The Administrator stated the nurse did not follow the Coumadin policy.</p> <p>Interview with Resident #1's attending physician, on 08/14/13 at 4:10 PM, revealed he was notified of the resident's change in behavior, and was told the resident had pulled on the catheter and had some bleeding. The physician revealed the nurse should have called him prior to the administration of the Coumadin due to the blood in the urine. The physician stated he would have withheld the Coumadin and checked the residents International Normalized Ratio (INR).</p> <p>A review of the discharge summary, dated 07/24/13, revealed a diagnoses of Hematuria secondary to indwelling catheter and urethral stricture, Anemia secondary to acute blood loss and Coumadin led to an increase in INR.</p>	F 309			