

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185341</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/08/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>402 W. FARTHING STREET MAYFIELD, KY 42066</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated survey ( KY #20037) was conducted on 04/24/13 through 05/08/13 to determine the facility's compliance with Federal requirements. KY #20037 was substantiated with Immediate Jeopardy determined to exist from 10/06/12 through 11/03/12 at 42 CFR 483.10 Resident Rights (F157) and 42 CFR 483.25 Quality of Care (F309) with Substandard Quality of Care at 42 CFR 483.25 Quality of Care.</p> <p>On 10/06/12 at 3:35 AM, Resident #1 was assessed to have a change condition. Resident #1 was having left lower extremity (LLE) pain and the Licensed Practical Nurse (LPN #1) assessed and determined the resident's LLE was swollen with four plus (4+) edema, was blue and there was no pedal pulse. However, LPN #1 was not concerned about the swelling and did not notify the Physician. LPN #1 passed information regarding the resident's condition to the on-coming shift in report. On 10/06/12 at 6:00 AM and at 8:30 AM, Registered Nurse (RN) #1 assessed there had been no improvement in Resident #1's condition. However, RN #1 did not attempt to call the Physician until 9:30 AM; approximately six (6) hours after the resident's change in condition was initially identified. Interview and record review revealed the Physician did not respond and a second attempt was made to contact the Physician at 10:15 AM, and again no response was received. Resident #1 was transferred to the Emergency Room at approximately 11:45 AM, at the request of the resident's family, and was diagnosed with an acutely ischemic left lower leg. Resident #1's condition worsened in the hospital; the resident</p>	F 000	Past noncompliance: no plan of correction required.		

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

TITLE

(X6) DATE

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 000	Continued From page 1 was transferred to Hospice Services on 10/08/12; and, the resident expired at the hospital on 10/09/12.  The facility developed and implemented interventions to correct the deficiencies effective 11/04/12. The State Survey Agency determined the facility completed all corrective action prior to the initiation of the investigation, thus resulting in the determination of Past Jeopardy. The facility was made aware of the Past Jeopardy on 05/08/13.	F 000			
F 157 SS=J	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	F 157			

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F 157	<p>Continued From page 2</p> <p>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> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review it was determined the facility failed to notify the Physician of a significant change in condition for one resident ( Resident #1), in the selected sample of five (5) residents. On 10/06/12 at 3:35 AM, Resident #1 was assessed to have a change in condition. Resident #1 was having left lower extremity (LLE) pain and the Licensed Practical Nurse (LPN #1) assessed and determined the resident's LLE was swollen with four plus (4+) edema, was blue and there was no pedal pulse. However, LPN #1 was not concerned about the swelling and did not notify the Physician. LPN #1 passed information regarding the resident's condition to the on-coming shift in report. On 10/06/12 at 6:00 AM and at 8:30 AM, Registered Nurse (RN) #1 assessed there had been no improvement in Resident #1's condition. However, RN #1 did not attempt to call the Physician until 9:30 AM; approximately six (6) hours after the resident's change in condition was initially identified. Interview and record review revealed the Physician did not respond and a second attempt was made to contact the Physician at 10:15 AM, and again no response was received. Resident</p>	F 157	Past noncompliance: no plan of correction required.		

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F 157	<p>Continued From page 3</p> <p>#1 was transferred to the Emergency Room at approximately 11:45 AM, at the request of the resident's family, and was diagnosed with an acutely ischemic left lower leg. Resident #1's condition worsened in the hospital; the resident was transferred to Hospice Services on 10/08/12; and, the resident expired at the hospital on 10/09/12.</p> <p>The facility's failure to notify the Physician of a significant change in condition caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 10/06/12 through 11/03/12. The facility implemented corrective action which was completed prior to the State Survey Agency's investigation, thus it was determined Past Jeopardy.</p> <p>Findings include:</p> <p>A review of the facility policy entitled, "Physician/Legal Representative Notification", last revised 10/12, revealed it was the policy of the facility to immediately consult with the resident's Physician; and if known, notify the resident's legal representative or an interested family member when there was 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) and/or when there was 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). The facility's procedure entailed the facility would notify the Physician as indicated above as</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>follows: The Charge Nurse should make two (2) attempts to notify the attending Physician. If unsuccessful, they should notify the Physician on call or the Medical Director. The Procedure for Legal Representative: The legal representative should be notified as indicated above. All notification(s) and/or attempted notifications should be documented in the Nurses' Notes.</p> <p>A record review revealed Resident #1 was admitted to the facility on 09/24/12 with diagnoses to include Hypertension, Macular Degeneration, Alzheimer's Disease, Hypothyroidism, Degenerative Joint Disease, Osteoporosis, Legal Blindness, Myocardial Infarction and Debility.</p> <p>A review of a Nurse's Note, dated 10/06/12 at 3:35 AM, documented by Licensed Practical Nurse (LPN) #1, revealed the LPN assessed Resident #1 as having leg pain most of the night, bilateral legs were swollen with four plus edema, the legs were blue and severely weeping and cold to touch. There was no pedal pulse in left lower extremity (LLE). Tylenol was given and the resident was repositioned and a warm blanket was provided. Further review of the Nurse's Note revealed there was no evidenced the LPN notified the Physician of Resident #1's change in condition.</p> <p>An interview with LPN #1, on 04/25/13 at 6:12 PM, revealed she provided care for Resident #1 on 10/06/12 and stated Resident #1 had swelling to the leg that evening. The LPN stated she told the oncoming staff at change of shift about the resident's condition. The LPN revealed if a resident had a change in condition, the Physician should be notified, and if they could not be</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>reached, the resident should be sent to the Emergency Room. However, she was not concerned about the swelling in Resident #1's and did not call the Physician.</p> <p>A review of a Nurse's Note, dated 10/06/12 at 6:00 AM, documented by Registered Nurse (RN) #1, revealed Resident #1 was sleeping, the LLE was swollen, weeping, and the RN was unable to palpate a pedal pulse. A review of a Nurse's Note, dated 10/06/12 at 8:30 AM, documented by RN #1, revealed Resident #1 did not eat any breakfast, the LLE continued to be swollen and weeping, the Nurse was unable to palpate a pulse, and the extremity cold. The resident's daughter (POA) was notified of the change in condition. However, there was no evidence the Nurse notified the Physician.</p> <p>An interview with RN #1, on 04/26/13 at 12:54 PM, revealed the RN provided care for Resident #1 on 10/06/12. The RN stated the resident's leg wasn't getting any better, was swollen with had no palpable pulse. However, the RN stated she did not attempt to notify the Physician until 9:30 AM because she got busy and forgot.</p> <p>Further review of the Nurse's Notes, dated 10/06/12 at 9:30 AM and 10:15 AM, revealed the on call Physician was called, approximately six (6) hours after the resident's change in condition was identified.</p> <p>A telephone interview with Physician #1, on 04/30/13 at 12:38 PM, revealed he was the on-call Physician on 10/06/12, but did not recall Resident #1 or receiving any calls regarding Resident #1.</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>A telephone interview with the Resident #1's Physician (Physician #2), on 05/01/13 at 2:51 PM, revealed the Physician should be contacted immediately when there was a significant change in a resident's condition.</p> <p>An interview with the Assistant Director of Nursing (ADON) and Director of Nursing on 05/02/13 at 3:10 PM and 3:15 PM respectively, revealed licensed staff should notify the Physician and the resident's family when a change of condition was identified. If they are unable to reach the Physician after two (2) attempts, the Medical Director should be called.</p> <p>A telephone interview with the facility's Medical Director, on 05/02/13 at 8:48 AM, revealed if there was a major change in a resident's condition, it would be best to contact the Physician.</p> <p>The facility implemented the following actions to correct the deficiency:</p> <ul style="list-style-type: none"> <li>* Resident #1 was discharged from the facility 10/6/12.</li> <li>* Licensed Nurses were in-serviced on 10/19/12, 10/23/12, 10/24/12, 10/27/12 and 11/2/12 by the DON and ADON on the following topics: Facility Notification Policy; Facility Alert Charting Policy and Procedure (which includes notification).</li> <li>* An audit of the 24 hour shift reports was done by the DON and ADON on 11/03/12 and continued through 2/20/13 indicating appropriate notification of the MD for changes in condition.</li> </ul>	F 157		
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F 157	<p>Continued From page 7</p> <p>As part of the audit process, the DON/ADON were determining that there was documentation of the findings of the resident assessment pertaining to the change in condition identified. As per the CQI schedule, the tool for monitoring compliance with notification was completed on 2/20/13 showing 100% compliance. The 24 hour shift reports are reviewed each morning, Monday - Friday (Monday includes a review of the weekend), by the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Minimum Data Set (MDS) Coordinator and Administrative team to determine compliance with MD notification of resident change in condition. The facility conducts a weekly (Tuesdays) Clinical Meeting consisting of the Charge Nurses from each unit, the interdisciplinary team, administrative Nurses, clinical team and the administrator to review each resident more in depth to identify if any MD notification is needed. Any needs identified are corrected at that time.</p> <p><b>**The State Survey Agency validated the corrective action taken by the facility as follows:</b></p> <p>Interviews with RN #2, LPN #1, LPN #2, LPN #3, LPN #4, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, SRNA #1 and SRNA #2 on 05/08/13 at 2:10 PM, 2:20 PM, 2:26 PM, 2:30 PM, 2:33 PM, 2:40 PM, 3:11 PM, 3:21 PM, 3:30 PM, 3:40 PM, and 3:55 PM respectively, revealed they were educated in regards to Physician/MD notification and resident change of condition. Staff were able to voice the components of the policy and procedures.</p> <p>Interview with the DON, on 05/08/13 at 4:26 PM,</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>revealed shift reports are reviewed every morning by the DON, ADON and the administrator. Weekend reports are reviewed on Monday. The reports are reviewed to identify any changes in the residents condition, and for proper Physician notification. On Tuesdays, the Charge Nurses join the team to give detailed clinical information regarding the residents. 24 hour shift report audits were done on 11/03/12 and continued through 2/20/13 with no concerns identified. When a significant change in condition is noted in a resident, the Nurse is to assess the resident and the INTERACT program is initiated. Depending on the condition of the resident would determine whether the Physician is contacted immediately. The staff is to notify the Physician, if unable to reach after two call, the staff will contact the emergency department to determine if another Physician is covering and if so contact that Physician. If still unable to reach the Physician, the facility's Medical Director will be contacted for orders. If the resident is having a medical emergency, staff would immediately contact 911 then proceed to notify the Physician. Facility CQI data is reviewed by the Nurse Consultant. The DON revealed that licensed staff education was provided by the DON/ADON on Physician notification. New employees are educated during new employee orientation.</p> <p>An interview with the facility Administrator, on 05/08/13 at 4:45 PM, revealed 24 hour shift reports are reviewed every morning by the Administrator, DON, ADON and members of the IDT team. On Mondays, a review is completed of the reports from Friday, Saturday and Sunday. On Tuesdays, the clinical staff is added to the team to provide specific resident details to the</p>	F 157			

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F 157	Continued From page 9 team. Staff communication is provided through the 24 hour report sheets as well as a verbal report is provided between staff at shift change. Regarding Physician notification, staff were educated following event on 10/06/12. Training was provided by the DON. The Administrator would expect Nurses to notify a Physician when they see a change in the resident condition. The process for notification is dependent on the immediacy of the change. If a medical emergency, staff would call 911 and initiate resident care, then the Physician and the family would be notified. The Physician would be contacted twice per policy, if unable to reach would contact the emergency department to determine who is covering for the Physician, if still unable to contact a Physician, the facility Medical Director should be contacted. Audits of the 24 hour shift reports have continued since the incident on 10/06/12 and the CQI process continues with no concerns identified. The administrator reports that the processes have been effective.	F 157			
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	Continued From page 10 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 (Resident #1), in the selected sample of five (5) residents. On 10/06/12 at 3:35 AM, Resident #1 was assessed to have a change in condition. Resident #1 was having left lower extremity (LLE) pain and the Licensed Practical Nurse (LPN #1) assessed and determined the resident's LLE was swollen with four plus (4+) edema, was blue and there was no pedal pulse. However, LPN #1 was not concerned about the swelling and did not notify the Physician. LPN #1 passed information regarding the resident's condition to the on-coming shift in report. On 10/06/12 at 6:00 AM and at 8:30 AM, Registered Nurse (RN) #1 assessed there had been no improvement in Resident #1's condition. However, RN #1 did not attempt to call the Physician until 9:30 AM; approximately six (6) hours after the resident's change in condition was initially identified. (Refer to F157) Interview and record review revealed the Physician did not respond and a second attempt was made to contact the Physician at 10:15 AM, and again no response was received. Resident #1 was transferred to the Emergency Room at approximately 11:45 AM, at the request of the resident's family, and was diagnosed with an acutely ischemic left lower leg. Resident #1's condition worsened in the hospital; the resident was transferred to Hospice Services on 10/08/12; and, the resident expired at the hospital on	F 309	Past noncompliance: no plan of correction required.		

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F 309	<p>Continued From page 11 10/09/12.</p> <p>The facility's failure to provide the necessary care and services to the resident caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 10/06/12 through 11/03/12. The facility implemented corrective action which was completed prior to the State Survey Agency's investigation, thus it was determined Past Jeopardy.</p> <p>Findings include:</p> <p>A record review revealed Resident #1 was admitted to the facility on 09/24/12 with diagnoses to include Hypertension, Macular Degeneration, Alzheimer's Disease, Hypothyroidism, Degenerative Joint Disease, Osteoporosis, Legal Blindness, Myocardial Infarction and Debility.</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 10/01/12, revealed the facility assessed Resident #1's cognition as severely impaired and the resident was totally dependent on staff for all activities of daily living (ADL's). There were no skin concerns identified.</p> <p>A review of the resident's every eight hour physical assessments, dated 09/24/12 through 10/01/12 on 6AM-2PM shift, revealed the facility assessed Resident #1 and determined the right and left lower extremity peripheral pulses were strong, capillary refill was brisk, and no edema was identified.</p> <p>Further review of the resident's every eight hour physical assessments, revealed on 10/01/12 on</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>the 2PM-10PM shift, the facility assessed Resident #1's right and left lower extremity pulses were weak. However, there was no documented evidence this change was further evaluated, or the Physician was notified.</p> <p>A review of a Nurse's Note, dated 10/06/12 at 3:35 AM, revealed Resident #1 was assessed by LPN #1 to have left lower extremity (LLE) pain for most of the night. The LLE was swollen with four (4) + edema, severely weeping, leg was blue, was cold to touch and there was no pedal pulse. However, there was no further documentation about the resident's condition until 6:00 AM and there was no documented evidence the resident's Physician was notified of this change in condition.</p> <p>A telephone interview with LPN #1, on 04/25/13 at 6:12 PM, revealed Resident #1 was assessed on 10/06/12 at 3:35 AM to have swelling to her leg. The LPN reported the resident had Peripheral Vascular Disease (PVD) so she elevated the residents feet and covered the resident with a warm blanket. She stated she was not concerned about the swelling because of the PVD. However, record review revealed no evidence the resident had a diagnoses of PVD. Per interview, LPN #1 continued to monitor the resident for the remainder of the shift and gave report to the on-coming shift. However, there was no documented evidence the resident was further assessed or monitored by LPN #1.</p> <p>A review of the physical assessment, dated 10/06/12 on the 6:00 AM-2:00 PM shift, and per interview completed by Registered Nurse (RN) #1 around 6:00 AM, revealed the RN assessed Resident #1's left peripheral pulse was absent</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>and the right peripheral pulse was weak, capillary refill was sluggish, and the left lower extremity had two plus (2+) edema.</p> <p>A review of a Nurse's Note, dated 10/06/12 at 6:00 AM, completed by RN #1, revealed the resident's LLE was swollen, weeping, and the RN was unable to palpate a pedal pulse. Further review revealed at 8:30 AM, RN #1 documented the resident's LLE continued to be swollen, was weeping, she was unable to palpate a pulse, and the resident's extremity was cold. At this time RN #1 called the resident's daughter to report the resident's condition. However, review of the Nurse's Notes revealed there was no attempt to contact the resident's Physician to report Resident #1's significant change in condition until 10/06/12 at 9:30 AM and 10:15 AM. Further review of the medical record revealed no evidence of a response from the Physician.</p> <p>A phone interview with RN #1, on 04/26/13 at 12:54 PM, revealed Resident #1 legs were assessed on 10/06/12 at 6:00 AM to have had no improvement and was not getting any better, with no pulse and swelling. However, she got busy with other residents and forgot to call the Physician. When RN #1 tried to call the Physician at 9:30 AM and 10:15 AM, she never heard back from the Physician. Per interview, the resident was then sent to the emergency department at the family's request at 11:45 AM.</p> <p>A review of a Nurse's Note, dated 10/06/12 at 11:45 AM, revealed Resident #1 was transferred by ambulance to the Emergency Room per the Power of Attorney's (POA) request.</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>A telephone interview, on 04/30/13 at 12:38 PM with Physician #1 who was the on-call Physician on 10/06/12, revealed that he did not recall Resident #1 or receiving any calls regarding Resident #1 on 10/06/12.</p> <p>A telephone interview, on 05/01/13 at 2:51 PM with Physician #2 who was Resident #1's attending Physician, revealed the Physician should have been contacted immediately when there was a significant change in the resident's condition. He was aware Physician #1 did not return the call to the facility and stated the resident should have been sent to the hospital for treatment.</p> <p>A telephone interview with the facility's Medical Director, on 05/02/13 at 8:48 AM, revealed it would be difficult to make the decision regarding Resident #1's leg without further information and stated it was not uncommon in the aging and elderly population to be unable to palpate a peripheral pulse. The Medical Director stated if a resident had a major change in condition, it would be best to contact the Physician.</p> <p>An interview with the Assistant Director of Nursing (ADON) and Director of Nursing on 05/02/13 at 3:10 PM and 3:15 PM respectively, revealed licensed staff should notify the Physician and the resident's family when a change of condition was determined. The staff should attempt to contact the Physician twice and if unable to reach they Physician the Medical Director may be contacted for orders. The family of a resident can also request that the resident be sent to the hospital.</p> <p>An interview with the Administrator on 05/02/13 at</p>	F 309		
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F 309	<p>Continued From page 15</p> <p>3:30 PM, revealed she expected staff to contact the Physician and the family with any changes in condition of a resident.</p> <p>The facility implemented the following actions to correct the deficiency:</p> <ul style="list-style-type: none"> <li>* Resident #1 was discharged from the facility 10/6/12.</li> <li>* Licensed Nurses were in-serviced on 10/19/12, 10/23/12, 10/24/12, 10/27/12 and 11/2/12 by the DON and ADON on the following topics: Facility Notification Policy; INTERACT 3.0 Program (which includes identifying a change in condition, Physician notification, assessment of the resident); Facility Alert Charting Policy and Procedure (which includes identifying change in condition, evaluating resident's needs, notification, care plan updating and follow-up documentation).</li> <li>* An audit of the 24 hour shift reports was done by the DON and ADON on 11/03/12 and continued through 2/20/13 indicating appropriate notification of the MD for changes in condition. As part of the audit process, the DON/ADON were determining that there was documentation of the findings of the resident assessment pertaining to the change in condition identified. As per the CQI schedule, the tool for monitoring compliance with notification was completed on 2/20/13 showing 100% compliance. The 24 hour shift reports are reviewed each morning, Monday - Friday (Monday includes a review of the weekend), by the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Minimum Data Set (MDS) Coordinator</li> </ul>	F 309			

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F 309	<p>Continued From page 16</p> <p>and Administrative team to determine compliance with MD notification of resident change in condition. As part of the daily review of the 24 hour shift report, staff review the resident chart to determine that documentation is present of the findings of the resident assessment pertaining to the change in condition. The facility conducts a weekly (Tuesdays) Clinical Meeting consisting of the Charge Nurses from each unit, the interdisciplinary team, administrative Nurses, clinical team and the administrator to review each resident more in depth to identify if any MD notification is needed. Any needs identified are corrected at that time.</p> <p><b>**The State Survey Agency validated the corrective action taken by the facility as follows:</b></p> <p>Interviews with RN #2, LPN #1, LPN #2, LPN #3, LPN #4, LPN #5 , LPN #6, LPN #7, LPN #8, LPN #9, SRNA #1 and SRNA #2 on 05/08/13 at 2:10 PM, 2:20 PM, 2:26 PM, 2:30 PM, 2:33 PM, 2:40 PM, 3:11 PM, 3:21 PM, 3:30 PM, 3:40 PM, and 3:55 PM respectively, revealed they were educated in regards to Physician/MD notification and resident change of condition. Staff were able to voice the components of the policy and procedures.</p> <p>Interview with the DON, on 05/08/13 at 4:26 PM, revealed shift reports are reviewed every morning by the DON, ADON and the administrator. Weekend reports are reviewed on Monday. The reports are reviewed to identify any changes in the residents condition, and for proper Physician notification. On Tuesdays, the Charge Nurses join the team to give detailed clinical information regarding the residents. 24 hour shift</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>report audits were done on 11/03/12 and continued through 2/20/13 with no concerns identified. When a significant change in condition is noted in a resident, the Nurse is to assess the resident and the INTERACT program is initiated. Depending on the condition of the resident would determine whether the Physician is contacted immediately. The staff is to notify the Physician, if unable to reach after two call, the staff will contact the emergency department to determine if another Physician is covering and if so contact that Physician. If still unable to reach the Physician, the facility's Medical Director will be contacted for orders. If the resident is having a medical emergency, staff would immediately contact 911 then proceed to notify the Physician. Facility CQI data is reviewed by the Nurse Consultant. The DON revealed that licensed staff education was provided by the DON/ADON on Physician notification and resident change in condition. New employees are educated during new employee orientation.</p> <p>An interview with the facility Administrator, on 05/08/13 at 4:45 PM, revealed 24 hour shift reports are reviewed every morning by the administrator, DON, ADON and members of the IDT team. On Mondays, a review is completed of the reports from Friday, Saturday and Sunday. On Tuesdays, the clinical staff is added to the team to provide specific resident details to the team. Staff communication is provided through the 24 hour report sheets as well as a verbal report is provided between staff at shift change. Regarding resident assessment, documentation and Physician notification, staff were educated following event on 10/06/12. Training was provided by the DON. The administrator would</p>	F 309			

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F 309	Continued From page 18 expect Nurses to notify a Physician when they see a change in the resident condition. The process for notification is dependent on the immediacy of the change. If a medical emergency, staff would call 911 and initiate resident care, then the Physician and the family would be notified. The Physician would be contacted twice per policy, if unable to reach would contact the emergency department to determine who is covering for the Physician, if still unable to contact a Physician, the facility Medical Director should be contacted. Audits of the 24 hour shift reports have continued since the incident on 10/06/12 and the CQI process continues with no concerns identified. The administrator reports that the processes have been effective.	F 309		
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