

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

PRINTED: 11/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2010
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431	
(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 annual survey was conducted 11/08/10 through 11/10/10 to determine the facility's compliance with Federal regulatory requirements. Deficiencies were cited with the highest scope and severity being an "E".	F 000		
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 the address and phone number of the resident's legal representative or interested family member.	F 157	It is the policy of NHC Madisonville to immediately notify the resident, attending physician, and responsible party, pertaining to significant changes in a resident's physical, mental, or psychosocial status. The notifications of physician and responsible party will occur 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 (for example, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications) ; a need to alter treatment significantly (for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment); or a decision to transfer or discharge the resident from the facility. It is the policy of the facility to notify the resident and the resident's responsible party in the event of a room change or a change in roommate assignment. Protocol and procedures that meet the Federal requirements are in place relating to the immediate notification of resident, physician, and responsible party to changes in resident condition. This process includes	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Danny Belman* TITLE: *adm* (X6) DATE: *1-20-11*

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

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined the facility failed to immediately notify the physician for two residents (#2 and #4), in the selected sample of 17. The facility failed to notify the physician for Resident #2 related to the administration of Intravenous (IV) potassium at an increased rate and not in accordance with the physician orders. The facility failed to notify the physician for Resident #4 regarding the development of a pressure sore. Findings include: A review of the policy/procedure, "When to Call the Physician Immediately", which was undated, revealed the physician should be notified immediately with any change in a resident's condition to include skin integrity or a wound. 1. Resident #2 was admitted to the facility, on 07/17/09, with diagnoses to include End Stage Dementia, Renal Failure, Hypo-osmolality and Hyponatremia. Resident #2 was admitted to the local hospital, on 10/29/10, with diagnoses to include Hypernatremia, Renal Failure and Volume Depletion. A review of the hospital History and Physical, dated 11/03/10, revealed the resident had refused to eat due to a diagnoses of Thrush. The family refused the placement of a feeding tube. On 11/03/10, the resident returned to the facility with the implementation of comfort measures. A review of the physician's orders revealed intravenous therapy with D5 1/2 Normal Saline (a combination of dextrose and Normal saline) with	F 157	the urgency and the method of notification. The immediate physician notification is made upon the professional judgment of the licensed nurse according to accepted standards of medical and nursing practice that reflect the Federal requirement. Resident # 2's physician was notified of the increased flow rate on 11-08-10 and an order was received for lab work. All labs for Resident # 2 were within normal limits. An IV pump was placed on Resident # 2 on 11-08-10 to control flow rate. All IV pumps are in working order. Resident # 4's physician acknowledged on 10-27-10 the awareness of the pressure area. A review of all other residents was completed by the DON and ADON regarding IVF's on 11-09-10 and no additional residents were receiving IVF's. All residents were reviewed by the DON and ADON to ensure proper documentation of notification of skin issues and no other residents were identified as affected. All current residents were evaluated, and assessed for determination of changes in clinical condition that would necessitate notification of physician or responsible party according to facility policy. These clinical changes included changes in vital signs, mental status, mobility status, or any other change outside their normal established baseline including significant changes in physical, mental, and psychosocial status.	

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F 157	<p>Continued From page 2</p> <p>20 millequivalents (MEQ) of potassium to be infused at a rate of 50 cubic centimeters (ccs) per hour.</p> <p>An observation, on 11/08/10 at 11:30 AM, revealed Resident #2 was in bed and D5 1/2 Normal Saline with 20 MEQ potassium was infusing by IV per gravity into the resident's right hand. The IV bag had no date and no time on the label, to indicate the time the IV was started. An observation revealed 650 ccs of fluid had been infused. An observation at 2:30 PM revealed 800 ccs of fluid had infused. An observation at 3:30 PM revealed 900 ccs had infused, for a total of 250 ccs which had infused over the four hour period.</p> <p>A review of the physician's orders, dated 11/03/10, revealed the IV potassium was to be infused at 50 ccs an hour, which would have resulted in an infusion of 200 ccs in the four hour period.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/08/10 at 4:35 PM, revealed the IV potassium was infusing too fast at approximately 18 drops a minute. She readjusted the flow rate to approximately seven drops per minute. She stated she wasn't sure how to calculate the appropriate number of drops per minute to equal the 50 ccs per hour rate. A manual regulator was in place on the IV tubing and was set at 50 ccs an hour; however, the IV fluid was infusing at more than 50 ccs an hour. She stated the IV bag had been initiated on 11/07/10 during the 3:00 PM to 11:00 PM shift. LPN #1 stated the manual flow regulators had been used by the facility for approximately one year. Although the facility had IV pumps, the pumps were not used because</p>	F 157	<p>In-service education was provided to licensed nursing staff by the DON on November 18 and 22, 2010 relating to immediate physician notification and patient status changes. In addition, the staff was educated on the process in the event the attending physician does not respond timely. There were no changes made to facility policy as the policy reflects the regulatory requirement. The content of the in-service addressed immediate physician notification.</p> <p>The Director of Nursing will monitor compliance of physician and responsible party notification through the Quality Assurance Process. The DON will review physician notification monthly x 3 beginning in December 2010 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.</p>	12/17/10	

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F 157	<p>Continued From page 3</p> <p>they were not working properly. Additionally, LPN #1 stated she had not received training related to the proper use of the manual regulators.</p> <p>An interview with LPN #2, on 11/08/10 at 4:45 PM, revealed she hung the unlabeled IV bag, on 11/07/10 at approximately 10:45 PM. LPN #2 stated approximately 700 ccs was still in the bag when she arrived on duty at 3:00 PM. She realized the rate was too fast when she hung the bag at 10:45 PM and she attempted to adjust the flow of the IV, using the wheel clamp on the tubing. She thought the rate was approximately 12.5 drops per minute. She was not aware the manual flow regulator was on the tubing. LPN #2 stated she did not notify the physician related to the IV potassium being infused at the wrong rate. Additionally, LPN #2 stated she had not received training related to the manual flow regulators.</p> <p>An interview with the Director of Nursing (DON), on 11/08/10 at 6:05 PM, revealed the physician should have been notified and informed the IV potassium was not administered per orders.</p> <p>An interview with Resident #2's physician, on 11/10/10 at 9:55 AM, revealed she was not made aware on 11/07/10 that the resident had received the potassium and fluids at a rate higher than ordered. The physician stated the resident was "a little short of breath" and potential complications included fluid overload, Hyponatremia and Congestive Heart Failure.</p> <p>2. A record review revealed Resident #4 was admitted to the facility, on 11/07/07, with diagnoses to include Cellulitis and Abscess of the Leg, Cerebrovascular Accident (CVA), Osteoarthritis, Osteoporosis, and Congested</p>	F 157		

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F 157	<p>Continued From page 4 Heart Failure.</p> <p>A review of the significant change Minimum Data Set (MDS), dated 09/27/10, revealed the facility identified the resident as modified cognitively independent, required limited assistance with ambulation and transfers and required extensive assistance with bed mobility.</p> <p>A review of the nurse's notes, dated 09/23/10 at 8:30 AM, at 9:15 AM and at 2:00 PM, revealed the resident was identified as having an unstageable pressure sore with black eschar present to the ball of the right foot. The area was noted to be painful to touch with redness to the surrounding tissue. The nurse's notes revealed a message was left on the physician's answering machine regarding the pressure sore.</p> <p>A review of the physician's orders, dated 09/23/10 at 1:45 PM, revealed an order was written for Allkare (skin protectant) to the ball of the right foot area every shift. The order was not signed by the physician. A notation, dated 10/27/10, made on the order by the primary physician revealed, "Was not notified of this skin lesion."</p> <p>An interview with the primary physician, on 11/09/10 at 12:20 PM, revealed she was not notified of the resident's pressure sore, until 10/27/10. She stated she did not receive a message on 09/23/10. She stated, "I expect staff to follow up on any fax or call if a response is not received."</p> <p>An interview with Registered Nurse (RN) #3, on 11/10/10 at 9:45 AM, revealed she placed a call to the resident's primary physician, on 09/23/10. She was unable to reach the physician and left a</p>	F 157			

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F 157	Continued From page 5 message on the answering machine at 9:15 AM, requesting a return call. She stated, "I apparently did not follow up with the physician." RN #3 stated the facility did not have a method that ensured physician notification. An interview with the MDS Coordinator, on 11/10/10 at 10:15 AM, revealed she discovered Resident #5's pressure sore during a skin assessment, on 09/23/10. The wound was unstageable and had necrotic tissue present. The assessment findings were reported to the charge nurse and the DON. She stated, "The charge nurse is responsible for notifying the physician." An interview with the DON, on 11/10/10 at 2:05 PM, revealed she expected acquired pressure sores to be reported to the physician immediately. When the physician did not respond to the message by the next day, the physician should have been called back. She stated, "We need a system in place on when to follow up with the physician."	F 157			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this	F 164	It is the policy of NHC Madisonville to protect the personal privacy and confidentiality of his or her person and clinical records. The staff member involved in the care of Resident # 9 received individual instruction from the DON regarding privacy on 11-10-10 Providing privacy practices to all other residents under the care of the facility will		

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F 164	<p>Continued From page 6 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, it was determined the facility failed to ensure privacy during a skin assessment for one resident (#9), in the selected sample of 17. Findings include:</p> <p>A review of the facility's policy/procedure, "Patient's Rights" dated 03/18/09, revealed "areas of dignity include but are not limited to the following: use of privacy curtains when performing care (visual privacy)."</p> <p>A record review revealed Resident #9 was admitted to the facility, on 04/21/09, with diagnoses to include Coronary Atherosclerosis, Cerebrovascular Disease, Mental Disorder, Hypercholesterolemia, Hyperlipidemia, Diabetes Mellitus, Osteoarthritis, Hypertension, Depressive Disorder and Peripheral Neuropathy.</p>	F 164	<p>protect their privacy. In addition, providing education to all staff protects all residents.</p> <p>All staff was educated regarding the resident's right to privacy on 11-22-10, 11-23-10, and 12-03-10. The DON provided the education to the staff.</p> <p>The Director of Nursing will monitor compliance of resident privacy practices through the Quality Assurance Process. The DON will review resident privacy practices monthly x 3 beginning in December 2010 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.</p>	12/17/10	

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F 164	Continued From page 7 An observation during a skin assessment, on 11/10/10 at 1:00 PM, revealed Licensed Practical Nurse (LPN) #6 did not ensure privacy was provided. The door to the resident's room was left open to the hallway and the privacy curtain were pulled only half-way around the resident's bed.	F 164			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	It is the policy of NHC Madisonville to assess, develop, review and revise the resident's comprehensive care plan. Resident # 2's IVcare plan was developed and implemented on 11-09-10 to reflect the administration of IVF's. An audit of all other residents revealed no other residents receiving IVF's therefore no other residents were affected. Going forward all residents receiving IV therapy will have a plan of care developed and implemented to reflect the IVF therapy. The DON provided education to all licensed nursing staff regarding the development and implementation of care plans for residents receiving IVF's on 11-22-10 and 12-02-10.		

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F 279	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure the care plan was revised to include measurable objectives and time tables to meet the resident's needs for one resident (#2), in the selected sample of 17, related to IV therapy. Findings include:</p> <p>Resident #2 was admitted to the facility, on 07/17/09, with diagnoses to include End Stage Dementia, Renal Failure, Hypo-osmolality and Hyponatremia. Resident #2 was admitted to the hospital, on 10/29/10, with diagnoses to include Hyponatremia, Renal Failure and Volume Depletion. The resident had refused to eat and the family refused a feeding tube placement. On 11/03/10, the resident returned to the facility with orders for comfort measures. The physician's orders included IV therapy with D5 1/2 Normal Saline with 20 mEq of potassium to be infused at 50 cubic centimeters (ccs) an hour.</p> <p>An observation, on 11/08/10 at approximately 11:30 AM, revealed Resident #2 was in bed with D5 1/2 Normal Saline with 20 MEQ potassium infusing per IV. The bag was not labeled with the date and time the infusion was initiated. The IV was observed to infuse into the resident's right hand per gravity. An observation revealed a total of 650 ccs had been infused. An observation at 2:30 PM revealed 800 ccs had been infused. An observation at 3:30 PM revealed 900 ccs had been infused, which represented a total of 250 ccs had infused over four hours.</p> <p>A review of the resident's clinical record revealed</p>	F 279	<p>The Director of Nursing will monitor compliance of care plans for residents with IVF's through the Quality Assurance Process. The DON will review care plans for residents with IVF's monthly x 3 beginning in December 2010 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.</p>	12/17/10	

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F 279	Continued From page 9 no care plan had been developed to address the IV therapy.	F 279			
F 281 SS=D	An interview with the Minimum Data Set (MDS) Coordinator/Registered Nurse (RN) #1, on 11/09/10 at 9:45 AM, revealed she was not aware a care plan had not been developed to address Resident #2's needs regarding IV therapy. RN #1 stated the nurse, who initiated the IV therapy, was responsible for initiation of a care plan to address the resident's needs. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure services provided by the facility meet professional standards for two residents, (#2 and #4), in the selected sample of 17 and two residents, (#18 and #22), not in the selected sample. The facility failed to ensure physician's orders were followed related to IV therapy for Resident #2. The facility failed to ensure Resident #4 wore non-skid socks and no shoes per physician's orders. The facility failed to ensure medications were administered per physician's orders for Residents #18 and #22. Findings include: 1. A review of the manufacturer instructions for the manual rate regulator revealed the flow rate should be verified against drip rate and adjusted slightly in the appropriate direction, until the	F 281	It is the policy of NHC Madisonville to provide or arrange for services that meet professional standards of quality. Resident #2's intravenous fluids were immediately placed on an electronic IV pump on 11-08-10 for accuracy and delivery of fluids in compliance with physician orders. Resident #4's non skid socks were applied per physician orders on 11-10-10. Resident #18's administration time for Effexor was changed to 6:30am, the Miralax order was confirmed and placed on the MAR on 11-09-10. On resident # 22 related to the late delivery of medication, the staff member involved was counseled individually and given education by the DON.		

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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
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F 281	<p>Continued From page 10 desired flow rate was obtained.</p> <p>Resident #2 was admitted to the facility, on 07/17/10, with diagnoses to include End Stage Dementia, Renal Failure, Hypo-osmolality and Hyponatremia. Resident #2 was admitted to the local hospital, on 10/29/10, and returned to the facility on 11/03/10, with orders for IV therapy of D5 1/2 Normal Saline with 20 mellequivalents (MEQ) of potassium to be infused at 50 cubic centimeters (ccs) an hour. Review of Resident #2's physician's orders, dated 11/03/10, revealed the IV potassium was to be infused at 50 ccs an hour which should have been 200 ccs in four hours.</p> <p>Observations on 11/08/10 at 11:30 AM, at 2:30 PM and at 3:30 PM, revealed the rate was increased and not in accordance with the physician's orders.</p> <p>Interviews with Registered Nurse (RN) #1, and Licensed Practical Nurses (LPN) #1 and #2, on 11/08/10 at 5:50 PM and at 6:20 PM, revealed they did not know the drops per minute were to be checked against the flow regulator setting and adjusted accordingly.</p> <p>An interview with the Director of Nursing (DON), on 11/08/10 at 6:05 PM, revealed she was not aware the dial regulators were being used instead of IV pumps. She stated potassium should be infused via pump, due to the potential for vein irritation if infused too fast and cardiac issues.</p> <p>An interview with the facility pharmacist, on 11/09/10 at 12:20 PM, revealed potassium was a drug requiring precision and caution with any administration, due to potential cardiac</p>	F 281	<p>All resident medication orders were reviewed by the DON, ADON, and licensed nursing staff to determine compliance with accepted standards. A process is in place effective 12-01-10 to ensure all new physician orders are reviewed daily by the licensed nurse team leaders to ensure compliance with physician orders.</p> <p>The DON and ADON provided education to all licensed nursing staff related to the administration of IVF's. Going forward all IVF's will be delivered by electronic pump on all residents with IVF orders to ensure compliance of rate and volume. The date of the in-service was 11-09-10.</p> <p>The DON provided education to all licensed nursing staff regarding safe medication administration on 11-17-10. Individual medication pass observation and IV skill competency completed 12-17-10.</p> <p>Education was provided to all licensed nursing staff by the DON on 11-18-10 and 11-22-10 related to obtaining and implementing physician orders.</p> <p>The DON provided education to all CNA staff related to specific individual resident needs. The education was completed 12-08-10.</p>		

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F 281	<p>Continued From page 11 complications.</p> <p>2. A review of the facility's policy/procedure "Medication Administration - General Guidelines," dated 05/2007, revealed : "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of the attending physician. Medications are administered within 60 minutes, before or after, scheduled time, except before or after meal orders, which are administered based on mealtimes."</p> <p>A record review revealed Resident #18 was admitted to the facility, on 06/05/03, with diagnoses to include Atrial Fibrillation, Bipolar I Disorder, Ataxia, Hypothyroidism, Esophageal Reflux, Hypertension, Tremor and Status Post Bilateral Hip Surgeries.</p> <p>A review of the physician's orders, dated 04/26/10, revealed: "Effexor 75 mg po at 7:00 AM daily, Effexor 37.5 mg po at noon, and Miralax one capful in eight ounces water or juice every morning."</p> <p>An observation during the medication pass, on 11/09/10 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #7 administered Effexor 75 milligrams (mg) by mouth (po) to Resident #18 and did not administer the Miralax.</p> <p>An interview with LPN #7, on 11/09/10 at 10:45 AM, revealed the Effexor was ordered for 7:00 AM administration, but she had administered the drug at 9:30 AM. LPN #7 stated she overlooked the Miralax. The Miralax was not listed on the</p>	F 281	<p>The Director of Nursing will monitor compliance of meeting professional standards through the Quality Assurance Process. The DON will review compliance of professional standards of care monthly x 3 beginning in December 2010 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.</p>	12/17/10	

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F 281	<p>Continued From page 12 MAR.</p> <p>3. A record review revealed Resident #22 was admitted to the facility, on 02/26/10, with diagnoses to include Atrial Fibrillation, Congestive Heart Failure, Atrisia and Stenosis of Aorta, Edema, Dyspnea/Respiratory Abnormality, Orthopnea, Anemia, Backache, Osteoarthritis, Hypertension, Depressive Disorder, Anxiety State, Debility and Muscle Weakness.</p> <p>A review of the physician's orders, dated 02/26/10, revealed: "Ranexa 500 mg one tablet po twice per day (BID); Neurontin 300 mg po three times per day (TID); and Ticlid 250 mg po BID with meals." The physician's orders, dated 11/01/10, revealed: "Erythromycin 500 mg BID, take for 30 days if still broke out, repeat for another 30 days." The BID times were listed as 8:00 AM and 4:00 PM; TID times were listed as 8:00 AM, 12:00 PM and 4:00 PM.</p> <p>An observation during the medication pass, on 11/10/10 at 9:15 AM, revealed RN #3 administered the medications past the appropriate 60 minute time frame.</p> <p>An interview with RN #3, on 11/10/10 at 10:20 AM, revealed she was aware the administration times were outside the required timeframe and had been delayed during the medication pass.</p> <p>An interview with the DON, on 11/10/10 at 10:30 AM, revealed she expected the nurses to follow physician's orders at all times and to ask for assistance with the medication pass, if needed.</p> <p>4. A record review revealed Resident #4 was admitted to the facility, on 11/07/07, with</p>	F 281			

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F 281	<p>Continued From page 13</p> <p>diagnoses to include Cellulitis and Abscess of the Leg, Cerebrovascular Accident (CVA), Osteoarthritis, and Osteoporosis. The resident had been treated by the wound care clinic on 11/01/10 and on 11/08/10 for an unstageable pressure sore to the bottom of the right foot.</p> <p>Review of the physician's order, dated 11/08/10, revealed bilateral feet were to be washed daily with bacteriostatic soap and water and rinsed. Bag balm should be applied to both feet and covered with non-skid socks.</p> <p>Observations of Resident #4, on 11/09/10 at 12:00 PM and on 11/10/10 at 1:00 PM, revealed the resident was wearing socks and shoes.</p> <p>A review of the Treatment Record dated November 2010, revealed the order was transcribed to the record on 11/08/10. The treatment was not initiated as completed on 11/09/10 or 11/10/10.</p> <p>An interview with Resident #4, on 11/10/10 at 1:00 PM, revealed she was not aware of the order to wear non-skid socks. She stated, "I have been putting my shoes on, nobody has ever told me not to."</p> <p>Interviews with Certified Nurse Aides (CNAs) # 1, #2, and #3, on 11/10/10 at 2:55 PM, at 3:00 PM, and at 3:05 PM respectively, revealed they were not aware the resident was to wear non-skid socks. CNA #3 stated, "I was never told Resident #4 could not wear shoes. The nurse told me the resident's foot was healed."</p> <p>An interview with RN #3, on 11/10/10 at 3:10 PM, revealed Resident #4 should not be wearing</p>	F 281			

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F 281	Continued From page 14 shoes, according to the physician's order, dated 11/08/10. She stated she was the charge nurse on 11/10/10 and she did not ensure the treatment was completed. She stated, "I really did not even remember the order had been added to the treatment record." An interview with LPN #4, on 11/10/10 at 3:40 PM, revealed she signed the order for the treatment on 11/08/10 and added the order to the treatment record. She did not ensure the care plan was updated to reflect the resident's treatment order. She stated she should have informed the CNAs the resident was not supposed to wear shoes. An interview with the DON, on 11/10/10 at 3:55 PM, revealed she expected the staff to follow physician's orders. She stated, "I am working on ways to improve the lack of communication."	F 281			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined the facility failed to ensure residents with pressure sores received necessary	F 314	It is the policy of NHC Madisonville to ensure that residents who enter the facility without pressure sores do not develop pressure sores unless the patient's clinical condition demonstrates the areas were unavoidable. Resident # 4 continues with an improving wound to her right foot. Ongoing daily treatment in compliance with physician orders is in place. The facility has processes in place to protect all other residents to minimize the potential for skin breakdown. This process includes daily skin checks by the CNA staff and weekly documented skin assessments by the licensed nursing staff. CNA staff report concerns and changes in skin		

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F 314	<p>Continued From page 15</p> <p>treatment and services to promote healing for one resident (#4), in the selected sample of 17. Findings include:</p> <p>A review of the policy/procedure, "Skin Integrity Prevention and Management" dated 01/01/06, revealed the physician should be contacted when pressure sores were present and specific orders should be obtained.</p> <p>A record review revealed Resident #4 was admitted to the facility, on 11/07/07, with diagnoses to include Cellulitis and Abscess of the Leg, Cerebrovascular Accident (CVA), Osteoarthritis, Osteoporosis, and Congested Heart Failure.</p> <p>A review of the significant change Minimum Data Set (MDS), dated 09/27/10, revealed the facility identified Resident #4 as modified cognitively independent, required limited assistance with ambulation and transfers, and required extensive assistance with bed mobility.</p> <p>A review of the nurse's notes, dated 09/23/10 at 8:30 AM and at 2:00 PM, revealed the resident was identified as having an unstageable pressure sore with black eschar (necrotic) present to the ball of the right foot. The area was painful to touch with redness noted to the surrounding tissue.</p> <p>A review of the weekly wound assessment record, dated 09/23/10, revealed the initial measurements of the wound were 0.7 centimeters (cm) in length by 0.7 cm in width. On 10/01/10, the weekly wound assessment record revealed measurements of 1.1 cm in length by 0.8 cm in width. Measurements on 10/07/10</p>	F 314	<p>integrity to the licensed nursing staff as they arise. The licensed nursing staff assess, document, and notify the physician to obtain treatment orders.</p> <p>The DON provided education to all licensed nursing staff on 11-16-10, 11-18-10, and 11-22-10 on physician notification and treatment orders. The DON provided further education to the licensed nursing staff on 12-01-10 regarding procedure when a pressure area is identified.</p> <p>The Director of Nursing will monitor compliance of skin integrity through the Quality Assurance Process. The DON will review compliance of skin breakdown monthly x 3 beginning in December 2010 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.</p>	12/17/10	

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F 314	<p>Continued From page 16 revealed 1.0 cm in length by 0.8 cm in width.</p> <p>A review of the physician's orders, dated 09/23/10 at 1:45 PM, revealed an order was written for Allkare (skin protectant) to the ball of the right foot area every shift. The order was not signed by the physician. A notation, dated 10/27/10, transcribed by the primary physician stated, "Was not notified of this skin lesion."</p> <p>A review of the physician's orders, dated 10/27/10 at 6:27 PM, revealed an order was written by the physician to consult with the wound care clinic for possible debridement of the pressure sore.</p> <p>A review of the Wound Care Progress Note, dated 11/08/10, revealed Resident #4 visited wound care, on 11/01/10, and significant debridement of the skin subcutaneous tissue under the right metatarsal head was performed.</p> <p>An observation during a skin assessment and wound care, on 11/08/10 at 3:50 PM, revealed a calloused area to the ball of the resident's right foot which measured 1.5 centimeters (cm) in length by 1.5 cm in width. The callous area had a black center which measured 0.3 cm in length by 0.2 cm in width. No treatment to the wound was performed.</p> <p>An interview with Registered Nurse (RN) #3, on 11/10/10 at 9:45 AM, revealed she placed a call to the resident's primary physician on 09/23/10, but was unable to reach the physician. A message was left on the answering machine at 9:15 AM requesting a return call. She stated, "I apparently did not follow up with the physician." RN #3 stated she wrote the order for the treatment on 09/23/10, without the physician's</p>	F 314			

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F 314	<p>Continued From page 17 approval.</p> <p>An interview with Licensed Practical Nurse (LPN) #5, on 11/10/10 at 10:45 AM, revealed she assessed the resident's pressure sore weekly and documented the findings on the Weekly Wound Assessment Record. The treatment Allkare (skin protectant) was applied every shift. LPN #5 revealed she was not sure what was beneath the necrotic area of the wound, but the Allkare was "drawing it out." She was aware the wound measurements increased during the period of 09/23/10 through 10/07/10 and she did not notify the physician.</p> <p>Interviews with the primary physician, on 11/09/10 at 12:20 PM and on 11/10/10 at 1:30 PM, revealed she was not notified regarding the resident's pressure sore until 10/27/10. The order was written for the referral to wound care at that time. She did not feel Allkare was an appropriate treatment for the resident's unstageable pressure sore and stated, "The appropriate thing would have been to notify me for treatment." She stated she would have ordered an appropriate dressing, depending on whether the wound was wet or dry. She revealed the eschar needed to be debrided and treated appropriately.</p> <p>An interview with Resident #4, on 11/10/10 at 1:00 PM, revealed when the pressure sore was discovered, it caused discomfort during ambulation. The resident stated, "It was so sore, I could not walk very good." Resident #4 revealed the pain had improved after debridement was performed.</p> <p>An interview with the Director of Nursing (DON), on 11/10/10 at 11:15 AM, revealed she was</p>	F 314			

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F 314	Continued From page 18 aware of the resident's pressure sore and the fact it had increased in size during the period of 09/23/10 through 10/07/10; however, she felt improvement was noted with the treatment using Allkare, although it was not ordered by the physician. She stated the charge nurse should not have written the physician's order without the physician's permission and the physician should have been made aware of the pressure sore.	F 314			
F 323 SS=E	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 reviews, it was determined the facility failed to ensure the resident's environment was as free from accident hazards as possible for two residents (#5 and #7), in the selected sample of 17 and thirteen (13) residents (#24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #35, #36, and #37), not in the selected sample, related to failure to assess residents for the use of assistive devices. The facility failed to assess Resident #26 for the use of a lift reclining chair. The facility failed to assess Residents #5, #7, #24, #27, #28, #29, #30, #31, #32, #33, #35, #36 and #37 for the use of air mattresses. Findings include: 1. Resident #7 was admitted to the facility, on	F 323	It is the policy of NHC Madisonville to provide a resident environment as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Resident # 5, #7, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #35, #36, and #37 were assessed based on risk factors / benefits related to the use of an air mattress and indications for side rail use. The residents were assessed by the DON and ADON the week of November 15 thru 19, 2010. Resident # 26 was assessed for lift chair safety on 11-12-10. Six (6) additional residents were identified with use of lift chairs and twenty-six (26) residents were identified with air mattress use. The above residents were assessed for need, risk, and safe use of the assistance device during the week of November 15 thru 19, 2010. Going forward residents requiring or requesting a lift chair or air mattress will be assessed for appropriateness and safe utilization prior to use.		

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F 323	<p>Continued From page 19</p> <p>07/12/10, with diagnoses to include Presenile Dementia, Altered Mental Status and Osteoporosis.</p> <p>An observation, on 11/08/10 at 2:30 PM, revealed Resident #7 was asleep in bed. An air mattress was in use with the setting of static flotation at normal pressure. A sensor alarm was in use and full siderails were raised on both sides of the bed.</p> <p>A review of the quarterly Minimum Data Set assessment (MDS), dated 10/25/10, revealed the facility identified Resident #7 as moderately cognitively impaired for decision making and required assistance of two staff for bed mobility and transfers.</p> <p>A review of the clinical record revealed no evidence of an assessment of the resident related to the use of the air mattress, prior to implementation.</p> <p>An interview with Licensed Practical Nurse (LPN) #8, on 11/09/10 at 3:00 PM, revealed she completed the assessment for the use of the siderails for Resident #7 and recommended the use of the full siderails based on the air mattress manufacturer's recommendation; however, the resident was not assessed for the use of the air mattress to determine risk factors and whether the combined use of the air mattress and siderails represented an accident hazard.</p> <p>An interview with the MDS Coordinator, on 11/10/10 at 4:50 PM, revealed the facility had never assessed residents, prior to the implementation of air mattresses or lift chairs. She stated the only assistive devices the facility assessed for residents' use were devices that</p>	F 323	<p>The DON provided education and in-service to all licensed on 11-22-10 related to risk assessment based on the use of lift chairs and air mattresses.</p> <p>The Director of Nursing will monitor compliance of accident hazards and assistance devices through the Quality Assurance Process. The DON will review compliance of accident hazards and assistance devices monthly x 3 beginning in December 2010 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.</p>	12/17/10	

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F 323	<p>Continued From page 20</p> <p>could potentially be considered a restraint, such as siderails, broda chairs, lap buddies, seat belts, personal and sensor alarms.</p> <p>An interview with the Director of Nursing (DON), on 11/10/10 at 5:30 PM, revealed the facility did not assess residents for the use of such assistive devices as air mattresses or lift chairs. The DON stated she was unaware of the facility conducting assessments for any electric operated device. The facility had no policy addressing the use of assistive devices.</p> <p>2. Resident #26 was admitted to the facility, on 01/03/08, with diagnoses to include Peripheral Vascular Disease, Anxiety and Lack of Coordination.</p> <p>An observation, on 11/09/10 at 1:20 PM, revealed the resident transferred himself/herself from a wheelchair to a lift chair/recliner without assistance. An alarm attached to the resident's wheelchair did not sound.</p> <p>A review of the significant change MDS, dated 09/09/10, revealed the facility identified Resident #26 as moderately cognitively impaired for daily decision making and required extensive assistance of two staff for transfers. A review of the fall risk assessment, dated 09/02/10, revealed the resident was identified at high risk for falls. Review of the clinical record revealed no documented evidence the resident was assessed for the use of the lift chair/recliner prior to implementation of its use.</p> <p>An interview with the MDS Coordinator, on 11/10/10 at 4:50 PM, revealed the resident was not assessed for the use of the lift chair/recliner,</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>prior to implementation. She stated the resident was supposed to have an alarm activated when up in the wheelchair, but the resident had been known to turn the alarm off and transfer himself/herself unassisted.</p> <p>3. Resident #27 was admitted to the facility, on 10/17/06, with diagnoses to include Dementia and Unspecified Late Effects of Cerebrovascular Disease.</p> <p>An observation, on 11/08/10 at 11:20 AM, revealed the resident was awake in bed. An air mattress was in place and set on normal pressure, the firmest setting.</p> <p>A review of the quarterly MDS assessment, dated 09/06/10, revealed the resident was identified as severely cognitively impaired for daily decision making and was totally dependent on two staff for transfers. A review of the fall risk assessment, dated 08/24/10, revealed the resident was identified as at high risk for falls. Review of the clinical record revealed no documented evidence the resident was assessed for the use of the air mattress before implementation of its use.</p> <p>4. Resident #28 was admitted to the facility, on 09/12/05, with diagnoses to include Other Persistent Mental Disorders due to Unspecified Psychosis and Osteoporosis.</p> <p>An observation, on 11/08/10 at 11:10 AM, revealed the resident had a fall mat in place on the right side of the bed and a low air loss mattress was in use with a setting on normal pressure at 275 pounds.</p> <p>A review of the significant change MDS, dated</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>08/17/10, revealed the resident was identified as moderately cognitively impaired for decision making and was totally dependent on two staff for transfers.</p> <p>A review of the comprehensive care plan, dated 08/17/10, with a revision date of 11/09/10, revealed the problem: "Risk for Falls related to impaired mobility, Stage 7 Dementia, Diabetes, Osteoporosis, Hypertension and Cerebrovascular Accident" with interventions which included reminders the resident had communication and cognitive deficits and was unaware of safety needs, required assistance with all transfers, had a history of falls and had the tendency to turn sideways while in bed, which placed the resident at risk for falls.</p> <p>Review of the clinical record revealed no documented evidence the resident was assessed for the use of the air mattress before it was implemented.</p> <p>5. Resident #29 was admitted to the facility, on 02/06/02, with diagnoses to include Cerebrovascular Accident with Hemiplegia and Unspecified Debility.</p> <p>An observation, on 11/08/10 at 11:15 AM, revealed the resident had an air mattress on the bed set on normal pressure and the firmest setting.</p> <p>A review of the quarterly MDS assessment, dated 09/23/10, revealed the resident was identified as moderately cognitively impaired for daily decision making and required extensive assistance of two staff for transfers. A review of the fall risk assessment, dated 09/20/10, revealed the</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>resident was identified as at high risk for falls. Review of the clinical record revealed no documented evidence the resident was assessed for the air mattress before it was implemented.</p> <p>6. Resident #5 was admitted to the facility, on 06/11/10, with diagnoses to include Pressure Sore, Diabetes Mellitus and Dementia.</p> <p>Observations, on 11/08/10 at 2:30 PM and at 3:30 PM, revealed Resident #5 was in bed on an air mattress with the setting at "normal".</p> <p>A review of the MDS assessment, dated 06/15/10, revealed the facility had identified the resident as moderately cognitively impaired and required extensive assistance with bed mobility and transfers. A review of the clinical record revealed no evidence the facility assessed Resident #5 to determine whether the use of the air mattress was safe for the resident, prior to implementation.</p> <p>7. Resident #30 was admitted to the facility, on 05/21/07, with diagnoses to include Congestive Heart Failure, Obesity, Lack of Coordination and Traumatic Amputation of the Legs.</p> <p>Observation, on 11/08/10 during the initial tour, revealed an air mattress was in use on the resident's bed.</p> <p>A review of the MDS assessment, dated 09/27/10, revealed the facility identified Resident #30 as requiring extensive assistance with bed mobility and was totally dependent for transfers. A review of the clinical record revealed no evidence of an assessment of the resident for the use of the air mattress, to determine safety, prior</p>	F 323		

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F 323	<p>Continued From page 24 to implementation.</p> <p>8. Resident #31 was admitted to the facility, on 09/11/03, with diagnoses to include Backache, Degeneration of Intervertebral Disc, Rheumatoid Arthritis and Dementia.</p> <p>An observation, on 11/08/10 during the initial tour, revealed an air mattress was in use on the resident's bed.</p> <p>A review of the MDS assessment, dated 09/29/10, revealed Resident #31 was identified as bedfast most or all of the time and required extensive assistance for bed mobility. A review of the clinical record revealed no evidence of an assessment to determine the safe use of an air mattress.</p> <p>9. Resident #32 was admitted to the facility, on 08/15/06, with diagnoses to include, Primary Dementia, Hypertension, Unspecified Osteoarthritis.</p> <p>A review of the significant change MDS, dated 08/31/10, revealed the facility assessed the resident as severely cognitively impaired and totally dependent for bed mobility, transfers, and activities of daily living.</p> <p>An observation, on 11/08/10 at 10:30 AM, revealed the resident was in bed with an air mattress in use.</p> <p>A review of the clinical record revealed no assessment for the safe use of the device. A review of the care plan, dated 09/14/10, revealed the resident was identified as at high risk for falls, related to impaired mobility.</p> <p>10. Resident # 33 was admitted to the facility, on 05/18/10, with diagnoses to include Primary Debility, Unspecified, Obesity, Cardiomegaly,</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>Myalgia and Myositis, hypertension, Diabetes, Chronic Airway Obstruction and Nephrotic Syndrome.</p> <p>A review of the significant change MDS, dated 07/14/10, revealed the facility assessed the resident as modified independent cognitively and required extensive assistance with bed mobility and total assistance with transfers.</p> <p>An observation, on 11/10/10 at 3:00 PM, revealed the resident was in bed with an air mattress in place.</p> <p>A record review revealed no assessment for the safe use of the device. A fall assessment, dated 07/15/10, revealed the resident was identified as at high risk for falls.</p> <p>11. Resident #35 was admitted to the facility, on 04/03/07, with diagnoses to include Muscle Weakness, Lack of Coordination, Late Effects of Cerebrovascular Disease, Essential Hypertension, Paget's Disease and Dysarthria. A review of the annual MDS, dated 08/03/10, revealed the facility assessed the resident as moderately cognitively impaired, required extensive assistance for bed mobility, and total assistance with transfers.</p> <p>A review of the care plan, dated 11/16/10, revealed the resident was assessed as at risk for falls, related to impaired mobility.</p> <p>An observation, on 11/10/10 at 4:30 PM, revealed the resident was in bed with an air mattress on the bed.</p> <p>A record review revealed no assessment for the safe use of the device. A fall assessment, dated 10/15/10, revealed the resident was identified as at high risk for falls.</p> <p>12. Resident #36 was admitted to the facility, on 04/14/05, with diagnoses to include Late Effects of Cerebrovascular Disease, Rt. Sided Weakness, History of Seizures, Neuropathy, Leg</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>Cramps, Edema, Hypertension and Diabetes Mellitus.</p> <p>A review of the quarterly MDS, dated 09/15/10, revealed the facility assessed the resident as moderately cognitively impaired, required extensive assistance with bed mobility, and total assistance with transfers.</p> <p>An observation, on 11/10/10 at 10:00 AM, revealed the resident was in bed with an air mattress on the bed.</p> <p>A review of the clinical record revealed no assessment for the safe use of the device.</p> <p>13. Resident #37 was admitted to the facility, on 07/24/08, with current diagnoses to include Osteoarthritis, and Osteoporosis.</p> <p>A review of the MDS, dated 09/16/10, revealed the facility assessed the resident as moderately cognitively impaired, and required extensive assistance for bed mobility and transfers.</p> <p>An observation, on 11/10/10 at 4:30 PM, revealed the resident was in bed with an air mattress on the bed.</p> <p>A record review revealed no assessment for the safe use of the device. A fall assessment, dated 09/02/10, revealed the resident was identified as at high risk for falls.</p> <p>14. A record review revealed Resident #13 was admitted to the facility, on 10/15/09, with diagnoses to include Psychosis, Alzheimer's Disease, Dementia, Hypertension, Arthropathy, Difficulty in Walking and Lack of Coordination.</p> <p>A review of the annual MDS, dated 10/19/10, revealed the facility identified Resident #13 as severely cognitively impaired and required extensive assistance with bed mobility, transfer and ambulation. A review of the Fall Risk Assessment, dated 10/13/10, revealed Resident</p>	F 323			

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F 323	Continued From page 27 #13 was at a high risk for falls. An observation, on 11/10/10 at 4:15 PM, revealed Resident #13 had a air mattress on his/her bed. The mattress was set to the firmest low pressure setting. A review of the clinical record revealed no evidence the facility assessed the resident to determine the safe use of the air mattress. 15. A record review revealed Resident #24 was admitted to the facility, on 03/22/10, with diagnoses to include Hypertension, Anxiety, Depressive Disorder, Malaise and Fatigue, Osteoarthritis and Osteoporosis. An observation, on 11/10/10 at 4:15 PM, revealed Resident #24 had an alternating pressure mattress set to the firmest normal air setting with siderails raised on both sides of the bed. A review of the annual MDS, dated 04/02/10, revealed the facility identified Resident #24 as moderately cognitively impaired and required extensive assistance with bed mobility, transfer, and ambulation. A review of the Fall Risk Assessment, dated 09/14/10, revealed the resident was at high risk for falls. A review of the clinical record revealed no evidence of an assessment of the resident for the use of the alternating air mattress.	F 323			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	It is the policy of NHC Madisonville to ensure the facility is free of medication error rates of five percent or greater.		

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F 332	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure that it was free of medication error rates of five percent or greater. Observations of medication passes on 11/08/10 through 10/10/10, revealed there was a total of 49 opportunities with six errors resulting in a 12 percent medication error rate. Findings include: A review of the facility's policy/procedure "Medication Administration - General Guidelines," dated 05/2007, revealed: "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of the attending physician. Medications are administered within 60 minutes, before or after, scheduled time, except before or after meal orders, which are administered based on mealtimes." 1. A record review revealed Resident #18 was admitted to the facility, on 06/05/03, with diagnoses to include Atrial Fibrillation, Bipolar I Disorder, Ataxia, Hypothyroidism, Esophageal Reflux, Hypertension, Tremor and Status Post Bilateral Hip Surgeries. A review of the physician's orders, dated 04/26/10, revealed: "Effexor 75 mg po at 7:00 AM daily, Effexor 37.5 mg po at noon, and Miralax one capful in eight ounces water or juice every morning." An observation during the medication pass, on	F 332	Resident #18's administration time for Effexor was changed to 6:30am, the Miralax order was confirmed and placed on the MAR on 11-09-10. On resident # 22 related to the late delivery of medication, the staff member involved was counseled individually and given education. The facility has implemented systems on 11-12-10 for checking daily and monthly the transcription accuracy of physician orders to ensure accuracy of medication administration for all residents. By implementing this process the risk for medication errors will be minimized for all residents. The 7-3 licensed nurse team leaders are responsible for reviewing all physician orders written for the preceding 24 hours with oversight provided by the DON and ADON. On 11-12-10 and 11-22-10 the DON provided education and in-service of safe medication administration to all licensed to nursing staff. Individual observation of safe medication pass for all licensed nursing staff was completed on 12-16-10. The observation of medication pass was completed by the Pharmacist, DON, and Assistant DON.	

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F 332	<p>Continued From page 29</p> <p>11/09/10 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #7 administered Effexor 75 milligrams (mg) by mouth (po) to Resident #18 and did not administer the Miralax.</p> <p>An interview with LPN #7, on 11/09/10 at 10:45 AM, revealed the Effexor was ordered for 7:00 AM administration, but she had administered the drug at 9:30 AM. LPN #7 stated she overlooked the Miralax. The Miralax was not listed on the MAR.</p> <p>2. A record review revealed Resident #22 was admitted to the facility, on 02/26/10, with diagnoses to include Atrial Fibrillation, Congestive Heart Failure, Atresia and Stenosis of Aorta, Edema, Dyspnea/Respiratory Abnormality, Orthopnea, Anemia, Backache, Osteoarthritis, Hypertension, Depressive Disorder, Anxiety State, Debility and Muscle Weakness.</p> <p>A review of the physician's orders, dated 02/26/10, revealed: "Ranexa 500 mg one tablet po twice per day (BID); Neurontin 300 mg po three times per day (TID); and Ticlid 250 mg po BID with meals." The physician's orders, dated 11/01/10, revealed: "Erythromycin 500 mg BID, take for 30 days if still broke out, repeat for another 30 days." The BID times were listed as 8:00 AM and 4:00 PM; TID times were listed as 8:00 AM, 12:00 PM and 4:00 PM.</p> <p>An observation during the medication pass, on 11/10/10 at 9:15 AM, revealed RN #3 administered the medications past the appropriate 60 minute time frame.</p> <p>An interview with RN #3, on 11/10/10 at 10:20 AM, revealed she was aware the administration</p>	F 332	<p>The Director of Nursing will monitor compliance of safe medication pass through the Quality Assurance Process. The DON will review compliance of medication pass monthly x 3 beginning in December 2010 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be continued by the DON or as directed by the Quality Assurance Committee.</p>	12/17/10	

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F 332	Continued From page 30 times were outside the required timeframe and had been delayed during the medication pass. An interview with the Director of Nursing, on 11/10/10 at 10:30 AM, revealed she expected the nurses to follow physician's orders at all times and to ask for assistance with the medication pass, if needed.	F 332			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	It is the policy of NHC Madisonville to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. RN nurse # 3 and LPN nurse # 4 has received individual counseling and education regarding hand-washing and wearing of gloves during treatment. The education and counseling will protect Resident # 4. The date of the individual counseling was 11-10-10. Education was provided to all staff related to hand-washing and wearing of gloves on 11-22-10, 11-23-10, 11-30-10, and 12-03-10. The DON provided instruction for the education. All residents are protected as a result of the education. The Director of Nursing will monitor compliance of Infection Control Practices through the Quality Assurance Process. The DON will review compliance of Infection Control Practice monthly x 3 beginning in December 2010 and report findings to the Quality Assurance Committee. The monitoring and in-service training will be		

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NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
(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 441	<p>Continued From page 31 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which hand washing was indicated by accepted professional practice for one resident (#4), in the selected sample of 17. Findings include:</p> <p>A review of the policy "Handwashing", dated 06/2003, revealed all personnel providing resident care should wash their hands. The policy revealed handwashing should be performed before and after caring for each resident.</p> <p>A record review revealed Resident #4 was admitted to the facility, on 11/07/07, with diagnoses to include Cellulitis and Abscess of the Leg, Cerebrovascular Accident (CVA), Osteoarthritis, Osteoporosis, and Congested Heart Failure.</p> <p>An observation during a skin assessment, on 11/08/10 at 3:50 PM, revealed Registered Nurse (RN) #3 and Licensed Practical Nurse (LPN) #4 did not don gloves prior to the skin assessment. RN #3 was observed to separate the resident's buttocks without wearing gloves. She continued</p>	F 441	<p>continued by the DON or as directed by the Quality Assurance Committee.</p>	12/17/10	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2010
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
(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 441	<p>Continued From page 32</p> <p>the assessment of the resident's peri-area without wearing gloves. RN #3 proceeded to the resident's chest area and beneath the resident's breasts without washing her hands and donning gloves. After the skin assessment was completed, RN #3 left the resident's room without washing her hands. A sink was observed available for use inside the resident's room.</p> <p>An interview with LPN #4, on 11/09/10 at 10:50 AM, revealed she normally wore gloves to perform a skin assessment and stated, "I just forgot to put on gloves."</p> <p>An interview with RN #3, on 11/09/10 at 11:05 AM, revealed she usually wore gloves to perform a skin assessment and did not know what happened. She revealed she should have donned gloves prior to the assessment and changed the gloves after touching the resident's private areas. She stated, "I thought I washed my hands before leaving the room."</p> <p>An interview with the Director of Nursing, on 11/10/10 at 2:05 PM, revealed she expected the nursing staff to don gloves prior to providing care to a resident, especially if they came into contact with the resident's peri-area. She stated the staff should have washed their hands before leaving the resident's room, since there was a sink available.</p>	F 441			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2010
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MADISONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431		
(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	
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 11/08/10 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			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.