

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

PRINTED: 06/23/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 05/26/2011
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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(F 000)	<p>INITIAL COMMENTS</p> <p>AMENDED (06/23/11)</p> <p>AMENDED (06/14/11)</p> <p>An onsite Revisit Survey was conducted 05/24/11 through 05/26/11 related to the Abbreviated/Partial Extended Survey concluded on 05/05/11. The Revisit Survey determined Immediate Jeopardy (IJ) had been removed on 05/12/11 at F-225, F-226, F-250, F-280, F-281, F-323, F-490, F-501, and F-520 on 05/12/11 as alleged in the acceptable Allegation of Compliance (AOC) received on 05/23/11. While the IJ was removed at F-225, F-226, F-250, F-280, F-281, F-323, F-490, F-501, and F-520, continued non-compliance remained as follows: F-225, F-226, F-280, F-281 at a S/S of a "D", F-250, F-323, F-501, F-490, and F-520 at a S/S of a "E". The facility's Quality Assessment and Assurance Committee had not completed the development and implementation of a plan to ensure correction of the deficient practice to prevent non-compliance recurrence.</p> <p>The non-IJ deficiencies, F-325, F-328, F-505, and F-514 cited during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 were not reviewed for compliance on 05/26/11 as the facility's Plan of Correction (POC) had not yet been reviewed for acceptance. Therefore, the deficiencies detailed on this statement of deficiencies for the Revisit Survey concluded on 05/26/11 include the F-325, F-328, and F-505 deficiencies identified on the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 as well as two (2) additional examples of non-compliance at F-514.</p>	(F 000)	<p>Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <div data-bbox="877 1346 1197 1533" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>JUL 29 2011</p> </div>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  <i>Admission</i>	(X6) DATE  7/15/11
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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)  F 157 SS=D	<p>Continued From page 1</p> <p>In addition, new deficiencies cited on the Revisit Survey concluded on 05/26/11 included F-157 and F-425 at a S/S of a "D".</p> <p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	(F 000)  F 157	<p>F 157</p> <p>The physician for resident #17 was notified on 5/25/11 that the Levsin was not administered as ordered for an 8:00am &amp; 8:00pm dose on 5/21/11 with order received to administer medication when it arrived from the pharmacy. The medication was obtained from the pharmacy on 5/25/11 &amp; continues to be administered as ordered.</p> <p>All residents would have the potential to be affected. Facility RN Consultants have audited every medication cart &amp; every MAR. The audit was completed on 6/03/11. The focus of this audit was to compare the MARs for each resident with the medication carts to verify that all medications were available &amp; being given as ordered. No other issues were identified with medications not being available as a result of the audit. The physician will continue to be notified when medication is not available to be administered as ordered.</p> <p>The physician &amp; the resident's legal representative or interested family member will continue to be notified when there is</p> <ul style="list-style-type: none"> <li>An accident involving the resident which results in injury and has the potential for requiring physician interventions</li> </ul>	

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F 157	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the Physician was notified for one (1) of thirteen (13) sampled residents (Resident #17). Resident #17 had an order for Levsin (medication used to reduce excess saliva production) which was not administered as ordered for an 8:00 AM and 8:00 PM dose on 05/21/11.</p> <p>The findings include:</p> <p>Record review revealed Resident #17 was admitted to the facility on 01/21/09 with diagnoses which included Adult Failure to Thrive, Quadriplegia, Head Injury, Pneumonitis due to other Solids and Liquids (Aspiration), and Gastrostomy Feeding Tube.</p> <p>Review of the Physician Orders, dated 06/12/11 revealed an order for Levsin drops, one (1) milliliter, twice a day (BID) for increased secretions.</p> <p>Review of the Medication Administration Record (MAR) dated 05/11 revealed Resident #17 did not receive the 8:00 AM or 8:00 PM dose on 5/21/11. Further review revealed the facility did not document a reason the 8:00 AM dose was not given but listed "not available".</p> <p>Review of the Nurse's Progress Notes, dated 05/21/11 at 4:38 PM revealed "suctioned large amounts thick white mucous so far this shift".</p> <p>Interview, on 05/24/11 at 1:30 PM, with Power of</p>	F 157	<ul style="list-style-type: none"> <li>• 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)</li> <li>• 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)</li> <li>• A decision to transfer or discharge the resident from the facility.</li> </ul> <p>To prevent the deficiency from re-occurring re-education was completed on 6/16/11 &amp; 6/29/11 by the ADON for all licensed nurses &amp; certified medication aides on the importance of notification of the MD when medications are not available to be given as ordered. Licensed nurses and certified medication aides were re-educated by the Facility RN Consultants regarding instances when the physicians should be notified on 7/12/2011 through 7/14/2011. Any new licensed nursing staff &amp; certified medication aides will receive this education during the orientation process.</p>	

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F 157		F 157	<p>To monitor facility performance to ensure the solutions are sustained through the QI process, the QI nurse will complete a QI audit of the MARs weekly, to include to include Resident #17 using a Med Cart Audit Tool to compare the MAR with the medications in the drawer to ensure that medications are available for administration as ordered &amp; that the MD has been notified in the event a medication is not available. Any issues identified will be corrected at the time of review with appropriate follow up action taken as indicated.</p> <p>To monitor facility performance to ensure the physician is notified of circumstances as listed in this regulations through the QI process, the Administrative Nurses including the DON, ADON, QI Nurse, MDS Nurses, and Staff Development Coordinator will continue to read the progress notes for all residents daily, Monday - Friday. Any issues identified will be corrected at the time of the review with appropriate follow up action taken as indicated.</p> <p>The results of these QI audits will be reviewed with the Administrator in the weekly QI Committee meeting, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse</p>	

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F 157	<p>Continued From page 3</p> <p>Attorney (POA) revealed the resident had an increase in oral secretions since she has been on this milk (tube feeding formula) and the doctor had ordered to change the milk on 05/18/11 but that still hadn't happened. The POA further stated she was concerned the resident was going to choke on her/his saliva and die because he/she is unable to call for help.</p> <p>Interview, on 05/25/11 at 9:30 AM, with Licensed Practical Nurse (LPN) #3 revealed the Levsin was ordered because the resident had marked increased oral secretions related to intolerance of tube feeding formula. She further stated the physician should have been notified on 05/21/11 of the Levsin not being administered at 8:00 AM as ordered. Continued interview revealed pharmacy made routine deliveries twice a day with medications and additional deliveries if a medication was needed immediately. She stated the physician should have been notified when the drug was not available.</p> <p>Interview on 05/25/11 at 11:30 AM with the Director of Nursing revealed the physician should have been notified when Resident #17 did not receive the medication as ordered at 8:00 AM on 05/21/11. She further stated the pharmacy should have been contacted when the drug was still not at the facility on 05/21/11 at 8:00 PM with notification to the physician regarding the medication order not being followed.</p> <p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or</p>	F 157	<p>and/or MDS Nurses, where the results of these audits will be compiled and assessed for trends by the Committee &amp; actions taken based on these assessments. Trends &amp; the accompanying action will be reviewed by the QI Executive Committee monthly, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, and/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p> <p>F 225 On the date of the alleged rape, March 25, 2011, the Administrator &amp; the ADON interviewed Resident #13 regarding her allegation of rape. The Administrator &amp; ADON also observed the bed &amp; room where Resident #13 alleged she had been raped. Neither the room nor the bed showed any obvious signs of activity other than Resident #13's regular activities of daily</p>	
(F 225) SS=D		(F 225)		

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[F 225]	<p>Continued From page 4</p> <p>mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Immediate Jeopardy identified</p>	{F 225}	<p>living. Resident #13's roommate was interviewed by the Administrator on March 13, 2011. The investigation into Resident #13's allegation was reopened on 3/31/11 by the Administrator. Employee time punch detail reports were reviewed by the Administrator to determine employees who worked the shift at the time of the report of the alleged rape. Additional witness statements were obtained from all employees with access to this resident. The local police department was notified on 3/31/11. A police officer conducted an interview with the resident on 3/31/11. The attending physician examined the resident on 4/1/11. The conclusion of the extended investigation, including review of the police report &amp; physician's report, was that no evidence exists to suggest or confirm Resident #13's allegation.</p> <p>All residents with reported allegations of abuse, neglect, or misappropriation would have the potential to be affected. A review was completed by the Administrator of any reported allegations in the past year to ensure each investigation had been completed thoroughly. No other concerns were identified. All resident's progress notes were reviewed by the DON/ADON on 5/6/11 - 5/9/11 to identify any potential allegations of abuse that may</p>	
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(F 225)	<p>Continued From page 5 during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 had been removed related to the facility having an effective system to ensure abuse allegations were thoroughly investigated and were reported to all appropriate officials. However, non compliance continued to exist at a S/S of an "D" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure appropriate investigation and reporting of abuse allegations.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC), received on 05/23/11, revealed the Administrator reviewed all allegations of Abuse in the past year to ensure each investigation was thorough. The Facility Registered Nurse (RN) Consultant re-educated the Administrator, the Director of Nursing (DON), Assistant DON, and Social Worker on conducting a thorough investigation of all allegations of abuse, neglect and misappropriation of property. All staff were educated by the Staff Development Coordinator on 05/11/10 to recognize events which must be reported according to the facility's policy for Abuse, Neglect, or Misappropriation of Property. The Nurse's Notes for all residents were reviewed by the DON/ADON on 05/06/11 through 05/09/11 to identify any potential allegations of abuse that may not have been investigated and none were identified. The facility further alleged the Facility RN Consultant would review all investigations prior to the five (5) day report to the appropriate agencies to ensure a thorough investigation was completed with appropriate documentation and reporting to the</p>	(F 225)	<p>not have been investigated. No other concerns were identified. All allegations of abuse, neglect, or misappropriation of property will continue to be investigated thoroughly &amp; reported to all the appropriate officials as indicated.</p> <p>To prevent the deficiency from re-occurring the Administrator, DON, ADON, and Social Worker were re-educated on 5/5/11 &amp; 7/14/11 by the Facility RN Consultant on conducting a thorough investigation of all allegations of abuse, neglect and misappropriation of property using the handout entitled "Guidelines for Investigating Allegations of Resident Abuse, Neglect, or Misappropriation of Property. All staff were re-educated by the Staff Development Coordinator beginning on 4/24/11 &amp; continued through 5/11/11 to recognize events which must be reported according to the facility's policy for Abuse, Neglect, or Misappropriation of Property. Any new staff will receive this information during the orientation process. To monitor facility performance to ensure that solutions are sustained through the QI process, the Facility RN Consultant will continue to review investigations for all residents, including Resident #13, prior to the five day report to the appropriate agencies to ensure a thorough investigation was</p>	
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(F 225)	<p>Continued From page 6.</p> <p>appropriate officials. The RN Consultant was to report the results of the reviews of all allegations of resident abuse monthly to the Quality Improvement Executive Committee.</p> <p>Interview with the Administrator, on 05/26/11 at 10:00 AM, revealed the facility's Quality Improvement (QI) Committee consisted of the Administrator, QA Nurse, facility RN Nurse Consultant, DON, ADON, Social Services Director, and other department heads as needed and the committee met weekly. She further stated the Quality Improvement (QI) Executive Committee consisted of the Medical Director in addition to the staff who attended the weekly QI Meeting and was to meet monthly. She stated the last Executive QI meeting was held on 05/11/11. Continued interview revealed the abuse investigations would continue to be monitored and the results of the reviews would be reported to the QI Committee weekly and the QI Executive Committee monthly.</p> <p>However, non-compliance continued to exist at a S/S of an "D" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure appropriate investigation and reporting of abuse allegations.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced</p>	(F 225)	<p>completed with appropriate documentation and reporting to the appropriate agencies. The results of the reviews of these allegations of resident abuse will continue to be reported monthly to the QI Executive Committee, consisting of the Administrator, DON, ADON, Medical Director, QI Nurse, Treatment Nurse, and/or MDS Nurses with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p> <p>F 226 The policy, "Abuse, Neglect, or Misappropriation of Resident Property" was reviewed by the Facility Registered Nurse Consultant on 5/5/11 &amp; determined to require no revision to meet the intent of this regulation. The investigation into Resident #13's allegation was reopened on 3/31/11 by the Administrator to be completed in accordance with the facility policy. Additional witness statements were obtained from all employees with access to this resident. The local police department was notified on 4/1/11 who conducted an interview with the</p>	
(F 226) SS=D		(F 226)		

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{F 226}	<p>Continued From page 7</p> <p>by: Based on interview and record review, it was determined the Immediate Jeopardy Identified during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 had been removed related to the facility implementing written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. However, non-compliance continued to exist at a S/S of an "D" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the facility's "Abuse, Neglect, or Misappropriation of Resident Property" Policy had been followed.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC), received on 05/23/11, revealed the facility's, "Abuse, Neglect, or Misappropriation of Resident Property" Policy was reviewed by the facility Registered Nurse (RN) Consultant and was found to require no revision. All resident Nurse's Progress Notes were reviewed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) to identify any potential allegations of abuse which may need to be investigated and none were identified. A review was completed by the Administrator of any reported allegations of abuse to ensure that all had been thoroughly investigated according to the facility's Abuse Policy and no issues were identified. The Facility RN Consultant re-educated the Administrator, the DON, ADON, and Social Worker on 05/05/11 on conducting a thorough investigation of all allegations of abuse, neglect and</p>	{F 226}	<p>resident. The attending physician examined the resident on 4/1/11.</p> <p>All residents would have the potential to be affected. All resident's progress notes were reviewed by the DON/ADON on 5/6/11 - 5/9/11 to identify any potential allegations of abuse that may not have been investigated. No concerns were identified. A review was completed of any reported allegations of abuse for the past year to ensure that all had been thoroughly investigated according to the facility's policy, "Abuse, Neglect, or Misappropriation of Resident Property Policy" with no further concerns identified. The facility will continue to investigate any allegation of abuse, neglect or misappropriation of resident property thoroughly per the facility policy.</p> <p>To prevent the deficiency from re-occurring the Administrator, DON, ADON, &amp; Social Worker were re-educated on 5/5/11 &amp; 7/14/11 by the facility's Registered Nurse Consultant on conducting a thorough investigation of all allegations of abuse, neglect, and misappropriation of property using the handout entitled "Guidelines for Investigating Allegations of Resident Abuse, Neglect, or Misappropriation of Property." Any new administrative nursing staff will receive this information during their orientation.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 05/26/2011
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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{F 226}	<p>Continued From page 8</p> <p>misappropriation of property. The facility further alleged the Facility RN Consultant would review all investigations prior to the final report to ensure a thorough investigation was completed with appropriate documentation and reporting to the appropriate officials. The RN Consultant was to report the results of the reviews of all allegations of resident abuse monthly to the Quality Improvement Executive Committee.</p> <p>Interview with the Administrator on 05/26/11 at 10:00 AM revealed the Quality Improvement (QI) committee which consisted of the Administrator, QA Nurse, facility RN Nurse Consultant, DON, ADON, Social Services Director, and other department heads as needed, met weekly. She further stated the Quality Improvement (QI) Executive Committee which consisted of the Medical Director in addition to the staff who attended the weekly QI Meeting were to meet monthly. Further interview revealed the last Executive QI meeting was held on 05/11/11. She stated, the abuse investigations would continue to be monitored and the results of the reviews would be reported to the QI Committee weekly and the QI Executive Committee monthly.</p>	{F 226}	<p>To monitor facility performance to ensure that solutions are sustained through the QI process, the Facility RN Consultant will continue to review the investigations of any reported allegations of abuse on any resident, including Resident #13, prior to the submission of the final report to ensure the facility has conducted a thorough investigation with proper documentation &amp; reporting of all alleged violations to the appropriate officials based on the facility's policy for abuse, neglect, or misappropriation of resident property &amp; provide additional guidance needed to ensure a thorough investigation has been completed. The Facility Registered Nurse Consultant will report the results of these reviews monthly to the QI Executive Committee, consisting of the Administrator, DON, ADON, Medical Director, QI Nurse, Treatment Nurse, and/or MDS Nurses with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	
{F 250} SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest</p>	{F 250}	<p>F250</p> <p>Resident #1 was transferred from the facility on 1/18/11 &amp; will not be readmitted. Resident #2 was removed</p>	

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(F 250)	<p>Continued From page 9</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Immediate Jeopardy identified during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 had been removed related to the facility providing medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. However, non compliance continued to exist at a S/S of an "E" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the the provision of medically related social services.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC), received on 05/23/11, revealed a review of the Nurse's Notes for all residents was completed by the Director of Nursing (DON), Assistant DON, Quality Improvement (QI) Nurse, Minimum Data Set (MDS) Nurse, Treatment Nurse, and/or Facility Consultant Nurses on 05/06/11 through 05/09/11 and was to continue daily to ensure medically related social services were provided to the residents until compliance was achieved. The facility staff were educated on 05/05/11 through 05/09/11 by the facility RN Consultant and/or DON/ADON on providing medically related social services and the facility's process for addressing</p>	(F 250)	<p>from the closed unit on 2/7/11. Resident #2 did not exhibit any signs of being negatively impacted by the interaction with Resident #1. Resident #13's concerns were reviewed &amp; discussed with the resident by the Social Worker on 3/31/11. The physician was made aware of resident #13's continued concerns by the licensed nurse on 3/31/11 &amp; orders were received for a psychiatric consult. The attending physician examined the resident on 4/1/11. Resident #13 was seen by the Psychiatrist on 4/2/11 with medication changes made. The Social Worker continued to follow up with the resident &amp; there have been no other concerns voiced by the resident. Resident #13 did make statements on 4/15/11 &amp; on 4/22/11 that she/he felt safe in the facility.</p> <p>All residents would have the potential to be affected. A review of the nurse's notes for all residents was completed by the DON, ADON, QI Nurse, Treatment Nurse, MDS Nurses, and/or Facility Registered Nurse Consultants on 5/6/11 thru 5/9/11 to ensure that medically related social services were provided for all residents with wandering, socially inappropriate, and/or disruptive behaviors. This review was to ensure that appropriate follow up action was being taken &amp; documented in the medical record by</p>	
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(F 250)	<p>Continued From page 10</p> <p>behaviors which included physician notification and/or transfer out of the facility if necessary with appropriate documentation by the Social Worker in the medical record. A "Social Services Referral" was implemented by the Administrator to notify the Social Worker of any potential concerns which may require social services interventions. Facility Staff were educated on 04/15/11, and 05/05/11 through 05/09/11 by the Administrator and DON on completion of the Referral to alert the Social Worker of behaviors which may require Social Worker interventions and in what instance this would be necessary. The Form would be give to to the Social Worker for follow up and a copy of the completed form was to be given to the DON to use for correlation during review of the Progress Notes. The DON, ADON, RN Supervisor, and for Facility RN Consultant would read the progress notes daily until compliance was achieved to ensure any identified needs were met by the Social Worker and also to ensure the Social Worker made the necessary documentation in the medial record. The facility further alleged the results of the medically related social services audits would be reviewed weekly by the QI Committee which consisted of the Administrator, DON, ADON, QI Nurse and MDS Nurse. The results of the medically related social services audits were to be reported monthly to the QI Executive Committee which consisted of the Medical Director and other staff as attended the weekly QI Committee.</p> <p>Interview with the Administrator on 05/26/11 at 10:00 AM revealed the Quality Improvement (QI) Committee met weekly and the Social Service audits were reviewed by the Committee. She</p>	(F 250)	<p>the Social Worker for any identified events. Any concerns identified were addressed as indicated with re-education of the staff as needed by the DON, ADON or Staff Development Coordinator.</p> <p>To prevent the deficiency from re-occurring the facility staff, including all licensed &amp; unlicensed staff were re-educated on 5/5/11 - 5/9/11 by the Facility Registered Nurse Consultant and/or DON/ADON on providing medically related social services &amp; the facility's process for addressing behaviors, such as wandering, socially inappropriate and/or disruptive behaviors which include physician notification and/or transfer out of the facility if necessary using the guidelines from the "Long Term Care Survey" manual, October 2010 edition, with appropriate documentation made by the Social Worker in the medical record. A communication tool titled, "Social Services Referral" was implemented by the Administrator to notify the Social Worker of any potential concern that may require medically related social services intervention. Education was initiated on 4/15/11 for facility Staff, including licensed &amp; unlicensed staff &amp; continued until 5/9/11 by the Administrator &amp; the DON &amp; again on 7/8/11 by the Facility RN Consultant on completion of this</p>	
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(F 250)		(F 250)	<p>tool to alert the Social Worker of any behaviors such as wandering, socially inappropriate, and/or disruptive behaviors that may require Social Worker intervention &amp; in what instances this may be necessary. The tool will be given to the Social Worker for follow up as indicated. A copy of the tool will also be given to the DON to be used for correlation that the intervention has been provided by the social worker. Any new licensed and unlicensed staff will receive this information during the orientation process.</p> <p>To monitor facility performance to ensure that solutions are sustained through the QI process, the DON, ADON, QI nurse, MDS Nurse, and/or Treatment nurse will continue to read the progress notes for all residents, including Resident #2 &amp; Resident #13, daily Monday - Friday, to ensure any identified needs continue to be met by the Social Worker. The Social Worker will be immediately made aware of any concerns by completion of the Social Services Referral tool with a copy also given to the DON. The results of these audits will be reviewed with the Administrator in the weekly QI Committee meeting, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse and/or MDS Nurse, where the results of these audits will</p>	

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{F 250}	<p>Continued From page 11</p> <p>further stated the Social Service audits were also reviewed in the Quality Improvement (QI) Executive Committee which consisted of the Medical Director in addition to the staff who attended the weekly QI Meeting and was to meet monthly to ensure compliance. She stated the last Executive QI meeting was held on 05/11/11.</p> <p>Non-compliance continued to exist at a S/S of an "E" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the the provision of medically related social services.</p>	{F 250}	<p>be compiled and assessed for trends by the Committee &amp; actions taken based on these assessments. Trends &amp; the accompanying action will be reviewed by the QI Executive Committee, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, and/or any other persons required to provide information pertinent to the reports being discussed, monthly with further retraining or other such interventions implemented as directed by the committee.</p>	
{F 280}	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>SS=D</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p>	{F 280}	<p>Completion Date: 07/28/2011</p> <p>F 280 Resident #33's Care Plan was revised on 6/1/11 by the MDS nurse to include assistance of 1 staff member with walker &amp; gait belt for assistance with transfers. Resident #34's Care Plan was revised on 5/26/11 by the MDS nurse to include the physician's order to elevate the left leg as much as possible until healed.</p> <p>All residents would have the potential to be affected. The comprehensive care plan &amp; resident care guide of all current residents were reviewed on 6/17/11 by the facility MDS nurses. The focus of this audit was to identify that the comprehensive care plan accurately reflected the current care &amp; services</p>	

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(F 280)	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for two (2) of thirteen (13) sampled residents (Resident #33 and #34).</p> <p>Resident #33's Care Plan was not revised in reference to the resident's functional status related to transfers after the resident sustained a fall with a fracture of the knee on 05/21/11.</p> <p>Resident #34's Care Plan was not revised related to a Physician's Order obtained on 05/13/11 to elevate the left leg as much as possible until healed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of Resident #33's medical record revealed diagnoses which included Dementia, and Acute Non-Displaced Fracture of the Patella. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/28/11 revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making. Further review revealed the facility assessed the resident as being independent with transfers and ambulation.</li> </ol> <p>Review of the Nurse's Notes dated 05/21/11 at 7:55 PM revealed the resident was found in the floor by a Certified Nursing Assistant (CNA) and a nurse. The Note further stated the resident had a dime size Hematoma noted to the top of the head and was complaining of pain in both knees. Further review revealed the Physician was</p>	(F 280)	<p>being provided and/or ordered for each resident. Corrections were made as indicated. All residents will continue to have revisions made to the comprehensive care plan by the interdisciplinary team, consisting of the MDS Nurse, Activities, Social Services, and or Dietary departments as determined by the RAI process, resident's needs &amp; preferences and/or physician's orders.</p> <p>To prevent the deficiency from re-occurring the interdisciplinary team consisting of the MDS Nurse, Activities Director, Social Worker, and Dietary Manager were re-educated on 6/21/11 by the Facility RN Consultant and the Administrative Nurses consisting of the DON, ADON, QI Nurse, and Staff Development Coordinator were re-educated on 7/14/11 by the Facility RN Consultants stressing the importance of accuracy in assuring that the comprehensive care plan, as well as the resident care guide, is revised with any changes in resident's needs and/or physician's orders. Any new members of the interdisciplinary team will receive this information during the orientation process.</p> <p>To monitor facility performance to ensure that solutions are sustained through the QI process, a QI audit will be conducted weekly, to include</p>	

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{F 280}	<p>Continued From page 13 notified and the resident was transferred to the emergency room at 8:40 PM.</p> <p>Further review of the Nurse's Notes dated 05/21/11 at 10:48 PM revealed the resident returned from the emergency room. Neuro-checks were resumed and the CT Scan of the head was negative. The Note further stated the resident had a possible Fracture of the Left Knee Cap and a left knee immobilizer was in place.</p> <p>Review of the X-Ray Report dated 05/21/11 revealed the resident had a possible, Acute Non-Displaced Fracture of the Left Patella.</p> <p>Observation of Resident #33 on 05/25/11 at 12:30 PM revealed the resident was in a geri-chair which was reclined, elevating the resident's legs. There was a knee immobilizer noted to the resident's left knee.</p> <p>Review of the Comprehensive Plan of Care dated 05/24/11 revealed the resident was at risk for falls related to impaired balance and had the potential for pain related to a Left Knee Fracture. The interventions included; Rehab Therapy Referral, call light in reach, monitor for dizziness, encourage to wear non skin socks and remind to wear shoes and socks when up out of bed, left knee immobilizer, keep left leg elevated as much as possible, and ice to left knee intermittently. However, there was no reference to the need for assistance with transfers related to the resident's Fractured Knee.</p> <p>Interview on 05/25/11 at 2:10 PM with the MDS Coordinator revealed she had updated the</p>	{F 280}	<p>Resident #33 &amp; Resident #34, by the QI Nurse or designee, using a QI Audit tool. This audit will be used to compare the comprehensive care plan &amp; the resident care guide to ensure that both have been updated to reflect the current care &amp; services being provided and/or ordered. The results of these audits will be reviewed with the Administrator in the weekly QI Committee Meeting, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, and/or MDS Nurse. Trends &amp; any accompanying actions will be reviewed monthly by the QI Executive Committee, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, &amp;/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MATHERS NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2923 CONCRETE ROAD</b> <b>CARLISLE, KY 40311</b>
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{F280}	<p>Continued From page 14</p> <p>resident's Plan of Care after the fall with the Left Knee Fracture to include interventions for ice to the left knee, knee immobilizer, and elevation of the left knee. She further stated she scheduled the resident for a Significant Change MDS related to the Knee Fracture. Further interview revealed the resident used to transfer and ambulate independently; however needed assistance at this time to stand and pivot with the assist of one staff member for transfers. Continued interview revealed the resident could stand an pivot with the assistance of one staff member and she had transcribed the intervention for transfers with assistance to the Care Guide for the CNA's to refer to, which was kept inside the resident's closet door. However, she stated she did not think about revising the Comprehensive Plan of Care related to transfer ability.</p> <p>2. Review of Resident #34's medical record revealed the resident was admitted to the facility on 03/17/11 with diagnoses which included Chronic Fractured Pelvis and Previously Fractured Left Hip.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 03/24/11, revealed the facility assessed the resident as having physical limitations which contributed to his/her dependent functional status for performing Activities of Daily Living (ADL's). Further review revealed the facility assessed the resident as needing assistance of two (2) staff persons for transfers, bed mobility, dressing, and toileting.</p> <p>Review of the facility policy, Resident Care Plan, dated 4/2007, revealed the facility provided a</p>	{F 280}		
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{F 280}	<p>Continued From page 15 written Care Plan based on Physician's Orders and the assessment of resident's needs. The Policy stated, modification of the Plan would be done as needed. Further review revealed any new problem or need of the resident would be addressed on the Care Plan.</p> <p>Review of a verbal Physician's Orders, undated, revealed an order to elevate the left leg as much as possible until healed. Further review revealed the order was received on 05/13/11.</p> <p>Review of Resident #34's Comprehensive Plan of Care revealed no intervention related to the Physician's Order to elevate left the leg as much as possible until healed.</p> <p>Review of the Nursing Progress Notes from 05/13/11 through 05/24/11 revealed only one documented entry which referenced elevation of the extremity.</p> <p>Interview on 05/26/11 at 2:10 PM with Licensed Practical Nurse (LPN) #2, revealed if a physician writes an order regarding leg elevation the information was to be transcribed to the Comprehensive Plan of Care and care giver report, not just communicated to staff as a FYI (for your information).</p> <p>Interview with the MDS Nurse on 05/25/11 revealed it would have been her responsibility to revise the Care Plan to reflect the Physician's Order to elevate the resident's leg.</p> <p>Interview on 05/25/11 at 3:20 PM with Resident #34's daughter, revealed she did not recall, except for the last couple of days, the resident's</p>	{F 280}		
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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{F 280}	Continued From page 16 leg being elevated during her visits. She further revealed she tried to visit daily for several hours.	{F 280}	F 281 A thorough respiratory assessment was completed for Resident #17 on 5/30/11 by the licensed nurse. No further change in condition was identified. The physicians' orders for Resident #17 were reviewed by the licensed nurse to ensure that all orders for Resident #17 were being followed. No other issues were identified.	
{F 281} SS=D	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, interview and record review, it was determined the facility failed to ensure services provided met professional standards of quality for two (2) of thirteen (13) sampled residents (Residents #17 and #35).  Resident #17 sustained a change in condition on 05/18/11, nausea and coughing up tube feeding and requiring suctioning several times. The physician was notified and a new order was received, however, there was no documented evidence of thorough assessment and monitoring of the change in condition such as resident needs related to intolerance of tube feeding and increased need for suctioning.  Also observation on 05/24/11 revealed Resident #35 did not have oxygen in place as ordered at 2/liters.	{F 281}	Resident #35 was re-assessed on 5/24/11 by the licensed nurse for the continued need for oxygen. The MD was made aware & new orders were received on 5/24/11 to discontinue the oxygen therapy related to multiple refusals by the resident to wear. The physicians' orders for Resident #35 were reviewed by the licensed nurse to ensure that all orders for were being followed. No other issues were identified.  All residents would have the potential to be affected. A QI audit was completed for all current residents on 6/16/11 by the DON, ADON, QI Nurse, Treatment Nurse, and/or MDS Nurses. This audit included a detailed reading of the nursing progress notes for the last 30 days to identify that evidence of an assessment and monitoring had occurred for any documented change	

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{F 281}	<p>Continued From page 17 The findings include:</p> <p>1. Record review revealed Resident #17 was admitted to the facility on 01/21/09 with diagnoses which included Adult Failure to Thrive, Quadriplegia, Head Injury, Pneumonitis Due to Other Solids and Liquids (Aspiration), and Gastrostomy Feeding Tube.</p> <p>Review of the Nursing Progress Notes on 05/18/11 entered at 5:21 PM revealed the physician was contacted regarding Resident #17's change in condition that included nausea, coughing up tube feeding and requiring suctioning several times. However, there was no evidence of acute care charting regarding follow-up to assessing and monitoring resident's needs and responses related to formula intolerance including discontinue pump tube feeding, response to resuming feeding and increased suctioning needs.</p> <p>Review of the Physician Orders dated 05/18/11 at 5:00 PM revealed an order to change the tube feeding related to intolerance of formula. An additional order was noted on 05/19/11 at 2:00 PM related to formula substitution until the formula ordered on 05/18/11 is available.</p> <p>Interview on 05/24/11 at 1:30 PM with Power of Attorney (POA) revealed the resident had increased oral secretions since being on the milk (tube feeding formula) and the doctor had ordered to change the milk on 05/18/11 but that still hadn't happened. The POA further stated she was concerned the resident was going to choke on the saliva and die because he/she is unable to call for help.</p>	{F 281}	<p>In condition. Any concerns identified were immediately addressed as indicated up to &amp; including a new assessment of the situation and/or MD notification if indicated. Any resident experiencing a change in condition will continue to have evidence of an assessment and monitoring of the change in condition documented in the medical record.</p> <p>An audit was conducted on 5/27/11 by the Facility Registered Nurse Consultants of all current residents receiving oxygen therapy. The focus of this audit was to ensure that oxygen was being administered as ordered. No other discrepancies identified were identified at that time. All residents requiring oxygen therapy will continue to have oxygen administered as ordered. An audit was conducted on 7/11/11 by Facility RN Consultants, ADON, QI Nurse, &amp; MDS Nurse of all current physician orders to ensure that all physician orders are being followed.</p> <p>To prevent the deficiency from re-occurring re-education was completed by the DON/ADON//Facility Consultants on 6/16/11 &amp; again on 6/29/11 for licensed &amp; unlicensed nursing staff stressing the importance of documentation of a change in condition as well as the necessity to have evidence of a thorough</p>	

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(F 281)	<p>Continued From page 18</p> <p>Interview on 05/25/11 at 9:30 AM with Licensed Practical Nurse (LPN) #3 revealed Resident #17 had a formula intolerance that resulted in increased need for suctioning related to oral secretions often several times a shift. Further interview revealed when the resident had an order to change the formula, the response to formula intolerance and subsequent feedings should have been documented in the nurses progress notes.</p> <p>Interview on 05/26/11 at 11:30 AM with LPN #3 revealed a resident's intolerance to a tube feeding formula which resulted in notification of physician and new orders for formula would be a significant change and required acute care charting each shift. Interview further revealed documentation should be in the progress notes regarding the resident's need for suctioning including the number of times the resident was suctioned each shift.</p> <p>2. Record review revealed Resident #35 was re-admitted to the facility on 05/16/11 following hospitalization due to Congestive Heart Failure.</p> <p>A review of the Physician Orders, dated 05/16/11, revealed an order for oxygen at two (2) liters per nasal cannula.</p> <p>Observation on 05/24/11 of Resident #35 at 2:00 PM and 3:00 PM revealed the resident was not receiving oxygen.</p> <p>Review of the Nursing Progress Notes, dated 05/24/11 at 2:19 PM, documentation which stated the resident was receiving oxygen at two (2) liters</p>	(F 281)	<p>assessment and monitoring of the change in condition documented in the medical record. Re-education was initiated by the Facility Consultant on 6/16/11 &amp; again on 6/29/11 for licensed &amp; non-licensed nursing staff on the importance of checking the resident care guide during rounds to ensure that residents received the care planned interventions, including oxygen, as ordered and that if residents refused any care planned interventions the nurse in charge of that resident must be made aware &amp; the MD must be notified. Any new licensed &amp; unlicensed nursing staff will receive this information during the orientation process. The DON, ADON, QI Nurse, MDS Nurses, Staff Development Nurse were re-educated on 7/14/11 by the Facility RN Consultants on using the pink copies of the physician's orders &amp; the daily reading of the progress notes to ensure that all physician's orders are being followed.</p> <p>To monitor facility performance to ensure solutions are sustained through the QI process the progress notes and pink copies of all physician's orders of current residents, including Resident #17 &amp; Resident #35, will continue to be read daily, Monday thru Friday, by the DON, ADON, QI Nurse, Staff Development Coordinator, Treatment Nurse, and/or MDS Nurses to identify</p>	

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(F 281)	<p>Continued From page 19</p> <p>as a specific intervention to prevent decline/deterioration related his/her respiratory status.</p> <p>Interview with the Director of Nursing (DON) on 05/24/11 at 4:00 PM revealed there had been a delay in assessing Resident #35's oxygenation saturation and notification of his/her physician in regard to the resident refusing to wear oxygen as ordered.</p> <p>Interview with the DON on 05/25/11 at 3:30 PM revealed there was an apparent communication failure that resulted in the nurses in charge of Resident #35's care were unaware for hours the resident had refused to use oxygen as ordered for most of the shift.</p> <p>Interview on 05/25/11 at 2:36 PM with LPN Applicant #4 revealed she did not realize Resident #35 was not wearing oxygen as ordered on 05/24/11. The interview further revealed it was at least five (5) hours the resident went without oxygen before oxygen saturation was measured and the physician notified on 05/24/11 at 3:30 PM.</p> <p>Interview with LPN #5 revealed twelve (12) hours prior to the physician being notified of Resident #35 refusal to wear the oxygen, the resident's assessment revealed a dramatic drop in oxygen saturation, measured at eighty-eight percent (88%) when oxygen was removed for fifteen minutes to see how the resident could tolerate being on room air.</p> <p>Interview on 05/26/11 at 4:00 PM with the Administrator revealed she realized through this</p>	(F 281)	<p>that any resident identified with a change in condition had evidence of an assessment &amp; monitoring documented in the medical record and that any new physician's orders are being followed. Any discrepancies will be addressed immediately as indicated up to &amp; including a reassessment of the resident and/or MD notification if needed.</p> <p>A QI audit will also be completed weekly by the QI nurse or designee to identify that any resident, to include Resident #17 &amp; #35, with orders for oxygen therapy is receiving oxygen as ordered. Any discrepancies will be addressed immediately as indicated. The results of these audits will be reviewed with the Administrator in the weekly QI Committee Meeting, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, and/or MDS Nurse. Trends &amp; any accompanying actions will be reviewed monthly by the QI Executive QI Committee, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, &amp;/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	

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(F 281)	Continued From page 20 Revisit Survey, the Administrative Nurses were not auditing as thoroughly as they should have been.	(F 281)	F 323 Resident #2 was moved to room 118 & monitored by staff to maintain a safe distance between Resident #1 & Resident #2. Resident #1 was monitored one-on-one until transferred from the facility on 1/18/11 after physical altercation with Resident #3 & will not be readmitted. Resident #2 was moved from the closed unit on 2/7/11.	
(F 323) SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Immediate Jeopardy identified during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 had been removed related to the facility providing supervision to prevent accidents. However, non compliance continued to exist at a S/S of an "E" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the environment remained as free of accident hazards as was possible; and each resident received adequate supervision and assistance devices to prevent accidents.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC), received on 05/23/11, revealed a visual observation of all residents and a review of the Nurse's Notes and twenty-four (24) Hour Report was completed on 05/06/11</p>	(F 323)	<p>Resident #3 was assessed by the nurse with no injuries noted. The nurse notified the physician &amp; resident's family.</p> <p>Resident #6 was transferred to the emergency room after assessment by the Registered Nurse. The employee involved with Resident #6 was suspended from the facility on 2/9/11 &amp; was terminated on 4/28/11. During this suspension period the employee did not work in the facility.</p> <p>All residents would have the potential to be affected. A visual observation of all residents &amp; a review of the progress notes &amp; 24 hour nursing reports were completed on 5/6/11 thru 5/9/11 by the Administrator, DON, ADON, MDS Nurses, &amp; Social Worker to ensure that interventions put into place for any resident identified with wandering, socially inappropriate and/or disruptive behaviors remains effective at reducing the risk of danger</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MATHERS NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2323 CONCRETE ROAD</b> <b>CARLISLE, KY 40311</b>
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{F 323}	<p>Continued From page 21</p> <p>through 05/09/11 by the Administrator, Director of Nursing (DON), Assistant DON, Minimum Data Set (MDS) Nurse and Social Worker to ensure interventions implemented for any resident identified with behaviors remained effective at reducing the risk of danger to others. The Administrator and Facility RN Consultant would be made aware of any wandering, socially inappropriate and/or disruptive behaviors immediately. Education was provided 06/05/11 through 05/09/11 for all staff regarding the need for the Administrator to be notified immediately in person or by phone of any behaviors to ensure immediate actions could be taken. The DON was to be notified if the Administrator was unavailable. The Administrator or DON were to also notify the Facility RN Consultant of the behaviors. The DON, Assistant DON, Quality Improvement (QI) Nurse, Minimum Data Set (MDS) Nurse, Treatment Nurse, and/or Facility Consultant Nurses were to read Notes and review the 24 Hour Report daily to ensure the interventions implemented for a resident identified with behaviors remained effective at reducing the risk of danger to others. The facility further alleged the results of the audits would be reviewed weekly in the QI which consisted of the Administrator, DON, ADON, QI Nurse and MDS Nurse. The results of the behavior audits were to be reported monthly to the QI Executive Committee which consisted of the Medical Director and other staff as attended the weekly QI Committee.</p> <p>Interview with the Administrator on 05/26/11 at 10:00 AM revealed the Quality Improvement (QI) committee met weekly to review behavior audits. She further stated the behavior audits were also</p>	{F 323}	<p>to others. A visual round was conducted by the Administrator, DON, Maintenance Director &amp; Environmental Services on 7/14/11 - 7/15/11 to identify hazards or risks in the resident's environment and to implement interventions to reduce any hazards or risks identified. The Administrator will continue to be made aware of any wandering, socially inappropriate and/or disruptive behaviors posing a risk to resident's or others immediately by the charge nurse &amp; actions will be taken based on the circumstances including contacting the Facility Registered Nurse Consultant as needed for additional guidance on dealing with these behaviors.</p> <p>To prevent the deficiency from re-occurring re-educated was provided on 5/5/11 thru 5/9/11 &amp; again on 7/8/11 for all staff by the DON/ADON/Facility Consultant regarding the need for the Administrator to be notified immediately in person or by phone of any wandering, socially inappropriate and/or disruptive behaviors to ensure immediate action could be taken as indicated. If the Administrator is unavailable staff has been instructed to contact the DON. The Administrator or DON will notify the Facility Registered Nurse Consultant of any reported wandering, socially inappropriate and/or disruptive</p>	
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F 323)		(F 323)	<p>behaviors posing a potential risk to others. All current facility staff was educated on 7/14/11 - 7/15/11 on the facility's Red Tag System Protocol for identification &amp; tagging of broken or malfunctioning equipment. Any new staff will receive this information during the orientation process.</p> <p>To monitor facility performance to ensure that solutions are sustained through the QI process, the progress notes and 24 hour reports for all residents, including Resident #2, will continue to be read by the DON, ADON, QI nurse, Treatment nurse, and/or MDS nurse daily, Monday - Friday to ensure that interventions implemented for a resident identified with behaviors remain effective at reducing the risk of danger to others. The results of these audits will be reviewed with the Administrator in the weekly QI Committee Meeting, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, and/or MDS Nurse. Trends &amp; any accompanying actions from these audits in additions to reports from the Falls, Wandering Residents, Restraints, Safety, Event &amp; Incident, and the Physical Plant Quality Improvement Committees will be reviewed monthly by the QI Executive Committee, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical</p>	
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<p>{F 323}</p> <p>{F 325} SS=D</p>	<p>Continued From page 22 reviewed in the Quality Improvement (QI) Executive Committee which consisted of the Medical Director in addition to the staff who attended the weekly QI Meeting and met monthly to ensure compliance. Further interview revealed the last Executive QI meeting was held on 05/11/11.</p> <p>Non-compliance continued to exist at a S/S of an "E" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the environment remained as free of accident hazards as was possible; and each resident received adequate supervision and assistance devices to prevent accidents.</p> <p>483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE.</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of facility policy it was determined the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (1) of twenty-nine (29)</p>	<p>{F 323}</p> <p>{F 325}</p>	<p>Director, &amp;/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p> <p>F 325 Resident #6 expired on 4/30/10.</p> <p>All residents would have the potential to be affected. An audit of the medical records for all current residents was completed on 5/6/11 by the Facility Registered Nurse Consultants to identify that any residents having a significant weight change have been assessed by the Dietician with nutritional interventions put into place and that residents were being weighed according to current facility policies &amp; protocols. No issues were identified in the audit. Nursing will continue to refer residents to the Dietician by completion of a diet order slip. These diet order slips will be placed in the Dietician's box located in the Dietary Manager's office. Residents showing a significant weight loss will continue to be assessed by the Dietician on his/her next visit with documentation of recommended nutritional interventions made in the medical record. In the event a consult is needed prior to the</p>	
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(F 325)	<p>Continued From page 23 sampled residents (Resident #6).</p> <p>The findings include:</p> <p>Review of the "Nutritional Assessment and Nutritional Monitoring of Nursing Home Residents Policy" with a revision date of 02/02, revealed "a nutritional assessment will be completed by the Dietician within seven (7) days of admission". "All assessments will include: calories, protein, fluid requirements, diagnosis, diet or tube feeding order, current labs, current medications, cultural, religious or ethnic food preferences if indicated, and nutritional recommendations".</p> <p>Review of the "Meeting Daily Fluid/Nutritional Requirements Policy" revised 05/09, revealed "each resident will have adequate nourishment to improve or maintain their status. The 11:00 PM -7: AM Nursing staff will monitor resident's Nutritional Sheet with regard to both fluid and meals/snacks intake. For those residents who have consumed 20% or less of two (2) consecutive meals; or those residents not within their daily required range of fluid intake, Nursing staff shall notify dietary and the Director of Nursing". Further review, revealed on day one (1) if a resident did not consume 20% or greater of two (2) consecutive meals, or refused two (2) consecutive meals, the 11:00 PM-7:00 AM nurse would notify the oncoming nurse during report and the resident would be monitored for the next twenty-four hours. On day two (2), if the resident continued to have poor nutritional intake, a Dietary consult would be made.</p> <p>Review of Resident #6's closed clinical record revealed the resident was admitted to the facility</p>	(F 325)	<p>next regularly scheduled visit, the RD will be available by phone.</p> <p>To prevent the deficiency from re-occurring, the "Nutrition at Risk" Committee consisting of the DON, ADON, Registered Dietician, and Dietary Manager will be responsible for monitoring all residents to ensure acceptable parameters of nutritional status are maintained through weekly &amp; monthly QI committee meetings. This committee was re-educated on 4/12/11 &amp; 5/10/11 by the Facility Registered Nurse Consultant on the current facility protocols for establishing base line weights on admission/readmission &amp; current facility policies and protocols for referral to the Registered Dietician and completing diet order slips for any Dietician consults as indicated and/or as ordered. These diet order slips are to be given to the Dietary Manager or placed in the Dietary mailbox. The Dietary Manager will ensure that these diet order slips are placed in the Dietician's box for follow up on the next scheduled visit. The Dietician will be contacted by phone in the event a consult is needed prior to the next regularly scheduled visit. Re-education was initiated by the DON/ADON/ Facility RN Consultant on 5/11/11 &amp; completed on 5/31/11 for licensed nursing &amp; dietary staff on completion</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>05/26/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MATHERS NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2323 CONCRETE ROAD CARLISLE, KY 40311</b>
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F 325)	<p>Continued From page 24</p> <p>on 04/20/10, with diagnoses which included a History of Aspiration Pneumonia, and Dysphagia. Further review revealed the Admission Minimum Data Set (MDS) Assessment had not been completed due to the recent admission date.</p> <p>Review of the Admission Physician's Orders and Progress Notes dated 04/20/10, revealed orders for a Pureed Cardiac Diet and Honey Thickened Liquids. A diagnosis of Dysphagia was noted on the Notes. Further review revealed orders for weekly weights for four (4) weeks.</p> <p>Review of the Initial Plan of Care revealed the resident had the potential for impaired nutrition, the goal stated; "weight will be maintained". The approaches included weigh weekly for four (4) weeks, then weigh monthly, assist with feeding if needed; and keep the physician notified of any changes.</p> <p>Review of the "24 Hour Food Intake and Output Record" revealed the resident refused breakfast, consumed 30% of lunch, and consumed 20% of supper on 04/21/10, refused breakfast on 04/22/10 (two consecutive meals with less than 20% consumed), consumed 70% of lunch, and refused supper on 04/22/10, consumed 40% of breakfast, 80% of lunch and 35% of supper on 04/23/10, consumed 40% of breakfast, 40% of lunch, and 20% of supper on 04/24/10, consumed 40% for breakfast, 20% for lunch and 20% for supper on 04/25/10, 15% for breakfast on 04/26/10 (three consecutive meals with 20% or less consumed), 40% for lunch and 30% for supper. On 04/27/10, the resident consumed 5% for breakfast and 5% for lunch (two consecutive meals with less than 20% consumed), 40% for</p>	{F 325}	<p>of the Diet Order slips for any referrals for Dietician consult and giving them to the Dietary Manager or placing them in the dietary box located outside the dietary department for follow up on her next scheduled visit. Any new employees will receive this information during the orientation process.</p> <p>To monitor facility performance to ensure that solutions are sustained through the QI process, a QI committee consisting of the ADON, DON, QI Nurse, Dietician, Administrator and/or Dietary manager will meet weekly to monitor all residents with significant weight loss/gain to ensure appropriate nutritional interventions have been implemented for these residents to ensure acceptable parameters of nutrition have been met.</p> <p>The results of these weekly meetings will be reported monthly to the QI Executive committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	

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(F 325)	<p>Continued From page 26</p> <p>supper, on 04/28/10 the resident consumed 10% for breakfast, 15% for lunch, and refused supper. On 04/29/10, the resident consumed 20% for breakfast (four consecutive meals with less than 20 % consumed).</p> <p>Further record review, revealed according to the Nutrition Policy, the initial notification to the dietitian and Director of Nursing (DON) should have been on 04/22/10 when the resident consumed less than 20% for two consecutive meals from 04/21/10 through 04/22/11. Resident #6 continued to consume less than 20% for two or more consecutive meals from 04/25/10 through 04/29/10. However, there was no documented evidence the Dietician was notified as per policy.</p> <p>In addition, record review revealed there was no documented evidence of a "Nutritional Assessment" completed by the Dietician. In addition, there was no documented evidence of a weight obtained after the admission weight of 157.3 pounds on 04/20/10.</p> <p>Interview on 02/07/11 at 1:30 PM with Registered Nurse (RN) #1 who worked on the south unit where Resident #6 resided, revealed she worked 7:00 PM until 7:00 AM and the nurses who worked the night shift were to add the totals on fluid intake for the twenty-four hour period and check the nutritional intake for the twenty-four hour period also. Further interview revealed she was aware of the Nutrition Policy; however, was unaware the policy had not been followed related to Resident #6.</p> <p>Interview on 02/12/11 at 2:15 PM with Certified</p>	(F 325)		
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(F 325)	<p>Continued From page 26</p> <p>Nursing Assistant (CNA) #2 revealed Resident #6's appetite was poor and the resident usually consumed from 20 % to 30% of the meal. She stated she would tell the nurses.</p> <p>Interview on 02/03/11 at 9:30 AM with CNA #20 revealed she was a restorative aide and the restorative aides were to assist residents who did not meet their nutritional requirements for food and fluids. She stated she remembered feeding Resident #6 at least twice and the resident took only a few bites, and stated she/he did not want anymore.</p> <p>Interview on 02/07/11 at 2:00 PM and 05/04/11 at 4:00 PM with the Director of Nursing (DON) revealed the policy was to have a Nutritional Assessment completed within seven (7) days by the Dietician. She further stated the Dietician was a consultant and was unaware of the policy. She stated she was unaware of who was responsible to ensure the Nutritional Assessment was completed within the 7 days. Further interview revealed the MDS Coordinators informed the Dietician of new admissions. After reviewing the "24 hour Food Intake and Output Record" for the resident, the DON stated the Dietician should have been notified of the resident's decreased food consumption by 04/28/10, and DON should have been notified; however, she did not remember being notified of the residents' decreased intakes. Continued interview revealed residents were ordered monthly weights on admission, and if residents had decreased intake the Dietician would be notified for recommendations including more frequent weights. She indicated if there was a Physician's Order for weekly weights, this should</p>	(F 325)		
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(F 325)	<p>Continued From page 27 have been done.</p> <p>Interview on 02/08/11 at 4:00 PM with MDS Coordinators #1 and #2, revealed they informed the Dietician and other disciplines of new admissions when they sent e-mails out a week before the Minimum Data Set (MDS) was due to be completed. Further interview revealed in April 2010, the Dietician did not have e-mail and the resident's name with the date the MDS was due was written on a bulletin board in the MDS office. The MDS Coordinators indicated the disciplines were informed of new admissions per the bulletin board.</p> <p>Interview on 02/07/11 at 3:20 PM with the Dietician, revealed the dietary policy was out of date, and she was unaware she was to see new admissions within seven (7) days. She stated her "norm" was to see residents by the fourteenth day of admission to complete the Nutritional Assessment. She reviewed the resident's "24 Hour Food Intake and Output Record", and stated she should have been notified of the resident's poor food consumption from 04/26/10 through 04/28/10. She stated she would have added nutritional interventions. She further stated she was in the building on Mondays and Thursdays during the time period of 04/10. Further interview revealed 1500 milliliters and twenty percent of meal intake was usually adequate to prevent weight loss.</p> <p>Interview on 05/05/11 at 2:15 PM with the Administrator verified the Dietician was the person responsible for completing the Nutritional Assessment; however, she would have to check the policy to find out who was responsible to</p>	(F 325)		

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(F 325)  (F 328) SS=D	<p>Continued From page 28 ensure the Dietician followed through.</p> <p><b>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</b></p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:                      Injections;                      Parenteral and enteral fluids;                      Colostomy, ureterostomy, or ileostomy care;                      Tracheostomy care;                      Tracheal suctioning;                      Respiratory care;                      Foot care; and                      Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:                      Based on observation, interview, and record review it was determined the facility failed to ensure residents received proper treatment related to respiratory care for one (1) of twenty-nine (29) sampled residents (Resident #11). Resident #11 had a Physician's Order for Oxygen to be dispensed at three (3) liters per minute (LPM) per nasal cannula (NC), to maintain Oxygen saturation (O2 SATS) at 90%. However, observation and interview revealed oxygen was dispensed at five (5) LPM per NC.</p> <p>The findings include:</p> <p>Observation of Resident #11 on initial tour on 03/29/11 at 2:40 PM, revealed Resident #11 resting with the head of the bed up thirty (30) degrees with two (2) pillows and one (1) neck</p>	(F 325)  (F 328)	<p>F 328 Resident #11's order for oxygen was clarified with the MD on 3/31/11 by the Licensed Nurse to be administered at 5L/min.</p> <p>All residents have the potential to be affected. Residents were reviewed by the Facility Registered Nurse Consultant on 3/31/11 to ensure that oxygen was flowing at the physician's prescribed rate &amp; that O2 saturation was being checked as ordered. No issues were identified at the time of the audit. Licensed nursing staff will continue to check oxygen rates during rounds and during medication pass to ensure that oxygen is flowing at the correct rate &amp; that O2 saturation is being documented on the MAR.</p> <p>To prevent the deficiency from re-occurring, licensed nursing staff were re-educated by the DON/ADON on 3/31/11 &amp; 4/12/11 stressing the importance of checking oxygen flow rates when making rounds and during medication pass by comparing their MAR with the current flow of oxygen being administered to ensure that oxygen is flowing at the correct prescribed rate for all residents as well as ensuring that O2 saturations are being checked as ordered and PRN if</p>	

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F 328)	<p>Continued From page 29</p> <p>pillow under his/her head. Oxygen (O2) was observed to be dispensing at five (5) liters per minute (LPM) per nasal cannula (NC). Observed on the wall behind the resident's head was a printed sign which read, "check the flow before you go", with a flow rate for the O2 to be at five (5) LPM.</p> <p>Record review revealed the facility admitted Resident #11 on 04/13/10, with diagnoses which included Chronic Obstructive Pulmonary Disease, Atrial Fibrillation and Anxiety.</p> <p>Review of Physician's Orders for March 2011, revealed an order for O2 to be dispensed at three (3) LPM per NC to keep O2 SAT levels above 90% .</p> <p>Interview with Kentucky Medication Aide (KMA) #5 on 03/30/11 at 3:10 PM, revealed her report from the off going shift stated Resident #11's O2 was at 5 LPM. She further stated she did not check the flow rate and the nurses checked the saturation level when they administered the breathing treatment.</p> <p>Interview with LPN #4 on 03/30/11 at 3:00 PM and 3:20 PM, revealed the O2 flow rate should be checked when staff make their initial rounds. She further stated the O2 saturation should be checked before and after administering breathing treatments; however, she did not check Resident #11's O2 saturation level before or after the breathing treatment on this date.</p> <p>Review of the facility's policy, "Pulse Oximetry", dated 02/07 revealed the procedure for obtaining a resident's oxygen blood content, however there</p>	{ F 328 }	<p>needed, &amp; documented appropriately on the MAR. Licensed nursing staff were also re-educated on 7/14/11 – 7/15/11 by the DON &amp; Facility RN Consultant on ensuring that residents receive proper treatment and care for special services including injections, parenteral &amp; enteral fluids, colostomy, ureterostomy or ileostomy care, tracheostomy care, tracheal suctioning, respiratory care, foot care &amp;/or prostheses as indicated and/or ordered. Any new licensed nursing staff will receive this information during the orientation process.</p> <p>To monitor that solutions are sustained through the QI process, weekly Resident Care Audits using a Resident Care QI Audit tool will be conducted by the QI Nurse on a 20% sample of current residents receiving special services including oxygen therapy, injections, parenteral and enteral fluids, colostomy, ureterostomy, or ileostomy care, tracheostomy care, tracheal suctioning, respiratory care, foot care and/or prostheses to ensure residents are receiving proper treatment and care as needed and/or ordered. Any issues identified during the audit will be corrected at that time with further retraining to occur with nursing staff as needed.</p>	
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[F 328]  F 425 SS=D	<p>Continued From page 30 was no evidence the policy contained the procedure for documenting the results.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 05/05/11 at 3:45 PM revealed the policy should have direction on where the results of the O2 SAT levels should be documented.</p> <p>Interview with the DON on 05/05/11 at 6:10 PM revealed the nurses initial on the Medication Administration Record (MAR) that O2 is administered and the O2 sats are above 90% but no percentages were recorded.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p>	{F 328}  F 425	<p>The results of these weekly audits will be reviewed with the Administrator in the weekly QI committee meeting, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse and/or MDS Nurse where the results of these audits will be compiled &amp; assessed for trends by the committee &amp; actions taken based on these assessments. Trends &amp; the accompanying action will be reviewed by the QI Executive Committee, consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting monthly with further action taken as directed by the committee.</p> <p>Completion Date: 07/28/2011</p> <p>F425 The physician for resident #17 was made aware by the licensed nurse on 5/25/11 that the Levsin was not administered as ordered from 5/21/11 through 5/24/11. The medication was obtained from the pharmacy on 5/25/11 &amp; continues to be administered as ordered.</p> <p>All residents would have the potential to be affected. Facility RN Consultants audited every medication cart &amp; every</p>	

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F 425	<p>Continued From page 31</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review it was determined the facility failed to provide routine medications in order to meet the needs of one (1) of thirteen (13) sampled residents (Resident #17). Resident #17 did not have the medication, Levsin (used to reduce excess saliva secretions), available from 05/21/11 through 05/24/11.</p> <p>The findings include:</p> <p>Record review revealed Resident #17 was admitted to the facility on 01/21/09 with diagnoses which included Adult Failure to Thrive, Quadriplegia, Head Injury, Pneumonitis Due to Other Solids and Liquids (Aspiration), and Gastrostomy Feeding Tube.</p> <p>Review of Physician Orders, dated 05/12/11 revealed an order for Levsin drops, one (1) milliliter, twice a day (BID) for increased secretions.</p> <p>Review of the 05/11 Medication Administration Record (MAR) revealed Resident #17 did not receive the 8:00 AM or 8:00 PM dose on 5/21, 5/22, 5/23, 5/24 and the 8:00 AM dose on 5/25. Record Review of the Progress notes, dated 05/21/11 at 4:38 PM revealed "suctioned large amounts thick white mucous so far this shift".</p> <p>Interview on 05/24/11 at 1:30 PM with Power of Attorney (POA) revealed the resident had increase in oral secretions since being on the milk (tube feeding formula) and the doctor had ordered to change the milk on 05/18/11 but that still hadn't happened. The POA further stated</p>	F 425	<p>MAR on 6/3/11. The focus of this audit was to compare the MARs for every resident with the medication cart to verify that all medications were available &amp; being given as ordered. Any issues identified as a result of the audit have been reported to the MD. The facility will continue to obtain &amp; provide medications for all residents as ordered. In the event that medication is not available the MD will be notified.</p> <p>To prevent the deficiency from re-occurring, re-education was completed by the ADON on 6/16/11 &amp; again on 6/29/11 for all licensed nursing staff on the facility protocol for obtaining medication to include; pulling the labels from current medications that need to be reordered from the pharmacy &amp; faxing these re-order labels to the pharmacy to be delivered at the next scheduled pharmacy delivery and completion of the early refill requests and submitting them to pharmacy for current medications as needed. For new medication orders staff were re-educated on the process to obtain the medication from emergency drug box if possible, contact back-up pharmacy #1 for delivery, contacting backup pharmacy #2 for delivery in the event it is unavailable from back up pharmacy #1 and on contacting the DON, ADON or on-call nurse for further assistance in</p>	

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F 425	<p>Continued From page 32</p> <p>she was concerned the resident was going to choke on saliva and die because he/she is unable to call for help.</p> <p>Interview on 05/25/11 at 9:30 AM with Licensed Practical Nurse (LPN) #3 revealed the Levslin was ordered because the resident had marked increased oral secretions related to intolerance of tube feeding formula. She also stated pharmacy makes routine deliveries twice a day with medications and additional deliveries if a medication is needed immediately.</p> <p>Interview on 05/25/11 at 11:30 AM with the Director of Nursing (DON) revealed the pharmacy should have been contacted when the drug was not available at 8:00 AM on 05/21/11 for the medication pass and contacted again when the medication was not at the facility by 8:00 PM the same day for the next routine dose.</p> <p>Interview on 05/25/11 at 3:10 PM with the facility Pharmacist revealed a fax request for a re-order on 05/21/11 at 11:45 AM noting the facility was out of Resident #17's Levslin. She could not determine why the drug was not sent to the facility later that day.</p> <p>Interview on 05/25/11 at 3:25 PM with the facility Pharmacy Manager indicated an error in manual processing showed the medication order was processed, therefore the pharmacy was unaware the facility had not received the medication. Further interview revealed the pharmacy had not been contacted since 05/21/11 so the pharmacy remained unaware the facility needed the Levslin medication. As soon as the pharmacy was contacted following a facility inquiry prompted by</p>	F 425	<p>obtaining medication if needed and notification of the MD if medications are not available. Any new licensed nursing staff will receive this information during the orientation process.</p> <p>To monitor facility performance to ensure that solutions are sustained, weekly QI audits will be conducted by the QI nurse or designee of all residents, including Resident #17, to ensure that medications are available &amp; being given as ordered. Any issues will be addressed immediately with further retraining of licensed staff as indicated. The results of these audits will be reviewed by the Administrator in the weekly QI committee meeting consisting of the Administrator, DON, ADON, QI Nurse, Treatment nurse and/or MDS nurse. The results of these weekly audits will be reported monthly to the QI Executive committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 05/26/2011
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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{F 490}	<p>Continued From page 34</p> <p>facility failed to effectively implement their Allegation of Compliance for past deficient practice, as evidenced by continued non-compliance in the areas of CFR 483.20 Resident Assessment, F-280 and CFR 483.20 Resident Assessment, F-281; although the facility deemed compliance on 05/12/11 for these deficiencies.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Immediate Jeopardy was identified on the Abbreviated Survey and Partial Extended Survey concluded on 05/06/11 for CFR 483.20 Resident Assessment, F-280 at a S/S of a "J". This was related to the facility's failure to revise the Comprehensive Plans of Care for sufficient interventions to prevent recurrence of Resident #1's aggressive behaviors towards Resident #2 and other residents.</li> </ol> <p>During the Revisit Survey concluded on 05/26/11, deficient practice was identified related to the facility's failure to revise residents' Plans of Care. Resident #33 sustained a Left Knee Fracture on 05/21/11; however, there was no documented evidence the Plan of Care was revised related to the resident's mobility status and transfer technique. Also, a new Physician's Order was obtained for Resident #34 to elevate the resident's left leg as much as possible until healed. However, there was no documented evidence the resident's Plan of Care was revised to reflect the new Physician's Order.</p> <p>Interview with the Administrator on 05/28/11 at 10:00 AM revealed the nurses made notes on the Communication Board in the computer, the Care</p>	{F 490}	<p>services are receiving these as ordered or that the MD had been notified if the resident refused.</p> <ul style="list-style-type: none"> <li>• Administering the facility by using trends identified through the QI Program to manage its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident.</li> </ul> <p>Any new administrative nursing staff will receive this information during the orientation process.</p> <p>To monitor performance to ensure that solutions are sustained daily communication will continue to be conducted by the Administrator with the Regional Vice President of Operations until compliance is maintained to ensure that established policies are implemented related to the management and daily operation of the facility to maintain compliance with minimum State and Federal requirements by providing a safe environment for each resident. The new DON will work with the Administrator to coordinate the care each resident receives and to assist in communicating with the Administrator and Medical Director when changes</p>	

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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(F 490)	<p>Continued From page 35</p> <p>Guides which were in the resident's closets and the twenty-four (24) hour report for any Care Plan updates which were needed. She further stated every morning the Administrative Nurses and Minimum Data Set Coordinators met to discuss any Care Plan revisions which were needed and to revise the Care Plans.</p> <p>2. Immediate Jeopardy was identified on the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 for CFR 483.20 Resident Assessment, F-281 at a S/S of a "J". This was related to the facility failing to provide necessary care and services to Resident #6 when the resident had signs of choking.</p> <p>During the Revisit Survey concluded on 05/26/11, deficient practice was identified related to the facility failing to ensure nursing care was provided in accordance with professional standards of care for Resident #17. Although Resident #17 sustained a change in condition on 05/18/11, which included nausea and coughing up tube feeding which required suctioning the resident several times, there was no documented evidence of thorough assessment and monitoring after the change in condition was noted related to the resident's intolerance of tube feeding and increased need for suctioning.</p> <p>Also, observation on 05/24/11 of Resident #35 at 2:00 PM and 3:00 PM revealed the resident was not receiving oxygen as per Physician's Orders at two (2) liters per nasal cannula; however, review of the Nurse's Progress Notes, dated 05/24/11 at 2:19 PM, revealed nursing documentation which stated the resident was receiving oxygen at two (2) liters.</p>	(F 490)	<p>occur that may affect the care and services each resident receives to ensure care is carried out daily by the direct care staff according to each residents individualized assessment and plan of care.</p> <ul style="list-style-type: none"> <li>• Rounds by the facility Administrator utilizing the Administrative Staff/Department Head Rounds Sheet &amp; rounds by the DON utilizing the Administrative Nurse Rounds Tool are ongoing daily, Monday – Friday, to ensure that each resident receives the care &amp; services to attain or maintain the highest practicable physical, mental, &amp; psychological well being of each resident.</li> <li>• Department Head meetings between the Administrator, DON, ADON, Housekeeping Supervisor, Social Worker, Activities Director, Dietary Manager, &amp; Rehab manager will continue to be held daily, Monday – Friday, to communicate any areas of concern &amp; any items related to resident care or services to the Administrator.</li> <li>• Weekly visits will continue to be made by the Regional Vice President of Operations</li> </ul>	

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(F 490)	Continued From page 36  Interview on 05/26/11 at 10:00 AM with the Administrator revealed the facility was to chart by exception and if there was a concern or issue with the resident, the resident was to be placed on "Acute Charting" and would be assessed, monitored with documentation until the condition resolved.  Further interview on 05/26/11 at 4:00 PM with the Administrator revealed she had just realized through this Revisit Survey, the Administrative Nurses were not auditing as thoroughly as they should have been.	(F 490)	and/or Facility Registered Nurse Consultant to provide additional oversight & guidance in ensuring the facility's resources are being used effectively & efficiently to ensure the delivery of the required care & services to the residents.  • An Executive QI committee, consisting of the Administrator, DON, ADON, Medical Director, QI Nurse, and/or any other Interdisciplinary team members as directed by the Administrator, will meet monthly to review the results of the weekly QI committee audits for trends & to direct further interventions as necessary for any identified concerns.	
(F 501) SS=E	483.75(I) RESPONSIBILITIES OF MEDICAL DIRECTOR  The facility must designate a physician to serve as medical director.  The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Immediate Jeopardy Identified during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 had been removed related to the facility ensuring the Medical Director was knowledgeable of problems related to care and services provided to residents in the facility in order for him to coordinate medical care in the facility. However, non compliance continued to exist at a S/S of an "E" as the facility had not completed the development	(F 501)	Completion Date: 07/28/2011  F501 The Administrator & DON were re-educated on 5/11/11 & again on 7/14/11 by the Facility Registered Nurse Consultant & the Regional Vice President of Operations on the responsibilities of the Medical Director that include implementation of	

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{F 501}	<p>Continued From page 37 and implementation of the Plan of Correction (POC) to ensure the Medical Director coordinated the medical care in the facility.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC), received on 05/23/11, revealed the Administrator and Director of Nursing (DON) were educated by the Facility Registered Nurse (RN) Consultant and Regional Vice President of Operations on the responsibilities of the Medical Director which included implementation of resident care policies and coordination of medical care in the facility. The duties and responsibilities were reviewed with the Medical Director on 05/11/11 by the Administrator and DON. The Executive Quality Improvement (QI) Committee met 05/11/11 which included the Medical Director. The Committee reviewed the Credible Allegation of Compliance and the Medical Director's role in assisting the facility to attain and maintain regulatory compliance. The Medical Director was apprised of current findings related to the facility's recent non-compliance including the results of audits of resident records. The Medical Director was to receive a written report on a weekly basis by the Administrator of any observations and investigations conducted as a result of the daily QI round tools and the weekly reports presented to the QI Committee..</p> <p>Interview with the Administrator, on 05/26/11 at 10:00 AM, revealed the facility's Quality Improvement (QI) Committee which consisted of the Administrator, QA Nurse, Facility RN Nurse Consultant, DON, ADON, Social Services</p>	{F 501}	<p>resident care policies &amp; coordination of medical care in the facility using the guidelines from the "Long Term Care Survey" manual, October 2010 edition. The duties &amp; responsibilities of the medical director position were reviewed with the Medical Director on 5/11/11 by the Administrator &amp; DON.</p> <p>A QI Executive committee consisting of the Administrator, DON, ADON, Medical Director, QI Nurse, Treatment Nurse, Physical Therapy, MDS Nurses, And/or Staff Development Nurse will continue to meet monthly to ensure the Medical Director remains knowledgeable of problems related to care &amp; services provided to residents in order for him/her to coordinate the medical care in the facility. In the event the Medical Director is unable to attend the monthly meeting he will be given a written report of the minutes of the meeting.</p> <p>The Medical Director will continue to receive weekly written reports from the Administrator of any observations and investigations conducted as a result of the daily QI rounds tools and the weekly reports presented to the QI committee.</p> <p>Completion Date: 07/28/2011</p>	

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{F 501}	Continued From page 38 Director, and other department heads as needed met weekly. She further stated the Quality Improvement (QI) Executive Committee which consisted of the Medical Director in addition to the staff who attended the weekly QI Meeting was to meet monthly. Further interview revealed the last Executive QI meeting was held on 05/11/11. She stated the Medical Director was to receive a written report every Friday to ensure he/she was aware of events in the facility. Continued interview revealed the QI Committee continued to audit for all deficiencies cited during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11.	{F 501}	F505 Resident #30 expired on 9/21/10.	
{F 505} SS=D	However, non-compliance continued to exist at a S/S of an "E" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure appropriate investigation and reporting of abuse allegations. <b>493.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</b>  The facility must promptly notify the attending physician of the findings.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure laboratory results were reported to the physician for one (1) of twenty-nine (29) sampled residents. Resident #30 had an elevated potassium level on 09/04/10. There was no documented evidence the physician was notified of the abnormal lab value and the resident continued to receive a potassium supplement.	{F 505}	All residents would have the potential to be affected. An audit was conducted on 4/20/11 & 5/10/11 by the facility Registered Nurse Consultants of current resident's lab results to ensure that abnormal results had been reported to the physician as needed. Any discrepancies identified at the times of the audits were reported to the attending physician.  To prevent the deficiency from re-occurring licensed nursing staff were re-educated on 7/14/2011 through 7/15/2011 by the DON/ADON and Facility RN Consultants on ensuring that critical laboratory results, as defined by the lab, are reported to the physician immediately and non-critical lab results are reported to the physician no later than the next day the physician is in the office, with	

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F 505)	<p>Continued From page 39</p> <p>The findings include:</p> <p>Review of the closed clinical record revealed Resident #30 was admitted on 03/08/07 with diagnoses which included Cellac Disease, Vitamin D Deficiency, Ricketts, and Severe Malnutrition. Continued review revealed the added diagnosis of Hypokalemia (low potassium in the blood) on 07/03/09. Other diagnoses included Hypertension, Chronic Obstructive Pulmonary Disease, and Coronary Artery Disease. Further review revealed the resident was admitted to Hospice Services on 09/17/10 and expired on 09/21/10.</p> <p>Review of the Physicians Orders revealed the resident was placed on potassium supplements, which were adjusted according to laboratory values. Continued review revealed the order for Potassium, 40 milliequivalents (mEq) daily, was written on 09/05/09.</p> <p>Review of the Physician's Order dated 09/03/10 at 5:00 PM revealed Resident #30 was to have a potassium level check completed. Review of the laboratory result dated 09/04/10 revealed the potassium level was elevated at 5.3, with the normal range being 3.5 - 5.1. Continued review of the report revealed no documented evidence the physician was notified of the abnormal value.</p> <p>Review of subsequent Physician's Orders revealed no adjustment to the potassium dose and no further checks of the potassium level were ordered.</p> <p>Review of the Medication Administration Record</p>	(F 505)	<p>documentation noted in the medical record. When lab results are received they will be called and/or faxed to the physician's office with documentation of this made either on a copy of the lab results or by note in the medical record. Any new licensed nursing staff will receive this information during the orientation process.</p> <p>To monitor performance to ensure solutions are sustained a weekly QI audit of the laboratory log of all residents will be conducted by the ADON or designee to ensure that laboratory results are reported to the physician in a timely manner and that evidence is documented in the medical record. Any potential concerns identified as a result of these audits will be addressed immediately with additional re-education to occur with the licensed staff as indicated. The results of these audits will be reviewed with the Administrator in the weekly QI committee meeting, consisting of the Administrator, DON, ADON, QI Nurse, and/or MDS Nurse where the results of these audits will be compiled &amp; assessed for trends by the committee &amp; actions taken based on these assessments. Trends &amp; the accompanying actions will be reviewed by the QI Executive committee, consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and</p>	

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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2328 CONCRETE ROAD CARLISLE, KY 40311
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(F 505)	<p>Continued From page 40 (MAR) for September 2010 revealed Resident #30 received Potassium, 40 mEq. daily, before and after the abnormal level was reported.</p> <p>Review of the policy titled Notification of Physician for Change in Resident's Condition (no date), "It is the policy of the facility to notify the physician when a significant change in a resident's condition occurs with documentation." The facility could not provide a policy specific to reporting abnormal laboratory values.</p> <p>Interview with Licensed Practical Nurse #8 revealed she was assigned to care for Resident #30 on 09/04/10 when the abnormal lab result came in. She stated she did not know where the report came from. She further stated if she had received it, her initials would have been on the report. Continued interview revealed she did not know the potassium level was high and did not report it to the physician.</p> <p>Interview with the Director of Nursing on 05/05/11 at 4:50 PM revealed all lab results should be reviewed by the nurse, signed, and dated. She stated any abnormal values should be called to the physician. Continued interview revealed routine lab orders were checked periodically by the unit secretaries to ensure they were completed. However, there was no tracking system for non-routine lab orders, such as Resident #30's order for a potassium level.</p> <p>Interview with the Attending Physician for Resident #30 on 05/05/11 at 5:20 PM revealed it was standard procedure for facility staff to call him with laboratory results. He stated had he been called, he would have held the potassium</p>	(F 505)	<p>any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	

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(F 505)	Continued From page 41 supplements and ordered follow-up lab tests. Continued interview revealed Resident #30 had multiple medical problems and was very ill during the last few weeks of life. The physician further stated the Cause of Death was Pneumonia. Although the elevated potassium level should have been reported and orders changed, he did not believe the elevated potassium level was a factor in the resident's death.	(F 505)		
(F 514) SS=D	483.76(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain clinical records on each resident that are complete and accurately documented for two (2) of thirteen (13) sampled residents (Residents #17 and #35).  Resident #17's Medication Administration Record (MAR) was not accurately completed 5/21/11 to	(F 514)	F514 Resident #17's MD was notified on 5/25/11 by the licensed nurse that the Levsin was not administered as ordered. The medication was obtained from the pharmacy on 5/25/11 & continues to be administered by the nursing staff as ordered. Resident #17's orders for gastrostomy tube were clarified on by the licensed nurse on 6/14/11 to include the size needed for G-tube replacement with the MAR updated to reflect this clarified order. Resident #35 was re-assessed by the licensed nurse on 5/24/11 by the licensed nurse for the continued need for oxygen. The MD was made aware & new orders were received on 5/24/11 to discontinue the oxygen therapy related to multiple refusals.  All residents would have the potential to be affected. Facility RN Consultants have audited every medication cart & every MAR/TAR. The audit was completed on 6/21/11. The focus of this audit was to review the MARs/TARs for every resident to verify that all medications were available & being given as ordered. Any issues identified as a result of the audit have been addressed as indicated.	

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F 514)	<p>Continued From page 42</p> <p>5/24/11 related to an order for Levsin (medication used to reduce excess saliva secretions) to be given twice a day at 8:00 AM and 8:00 PM. Further review of the resident's MAR revealed no evidence of the descriptive orders, dated 05/21/11 for changing the resident's gastrostomy tube (G-tube, feeding tube) or documentation that the tube was changed.</p> <p>In addition, Resident #35's Nursing Progress Notes stated on 05/24/11 at 2:15 PM, "resident receiving oxygen via nasal cannula at two (2) liters". However based on surveyor observation and interviews with the facility staff it was determined the resident had not been wearing oxygen for several hours prior to that documentation.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review revealed Resident #17 was admitted to the facility on 01/21/09 with diagnoses which included Adult Failure to Thrive, Quadriplegia, Head Injury, Pneumonitis Due to Other Solids and Liquids (Aspiration), and Gastrostomy Feeding Tube.</li> </ol> <p>Review of Physician Orders, dated 05/12/11 revealed an order for Levsin drops, one (1) milliliter, twice a day (BID) for increased secretions.</p> <p>Review completed on 05/24 of May MAR revealed no documented evidence Resident #17 received the 8:00 AM or 8:00 PM dose on 5/21, 5/22, 5/23, 5/24 and the 8:00 AM dose on 5/25. However, the reason was not listed for doses not given on 05/21 at 8:00 AM, 05/23 at 8:00 PM,</p>	(F 514)	<p>An audit was completed on 6/14/11 by the Facility RN Consultants of all residents with gastrostomy tube orders. The focus of this audit was to identify that these orders included descriptive orders for changing the resident's tube that includes the size of the replacement tube to be used &amp; that documentation was being completed on the MAR when these tubes were replaced. Any issues identified as a result of this audit have been addressed as indicated.</p> <p>An audit was conducted by the Facility RN Consultants on 6/13/11 &amp; 6/21/11. The focus of the audit was to ensure that all current residents with oxygen were receiving oxygen as ordered. Any concerns identified as a result of this audit were corrected as indicated.</p> <p>To prevent this practice from re-occurring there has been a change in the nursing leadership of the facility. The DON resigned from the position on 5/26/11. An Interim DON was assigned to the position pending the start date of a new DON. The new DON assumed the role as of 7/5/11 to assist the Administrator with the oversight to ensure that the resident's needs are met. Re-education was completed by the ADON on 6/16/11 &amp; again on 6/29/11 for licensed &amp; unlicensed nursing staff regarding the appropriate</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 05/26/2011
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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{F 514}	<p>Continued From page 43</p> <p>05/24 at 8:00 AM and 05/24 at 8:00 PM and 05/25 at 8:00 AM. The MAR revealed the 8:00 AM dose on 05/23 and 05/24 were not given, however, there was no identification of who recorded the medication attempt. On 05/23 the 8:00 PM dose was initiated as given when in fact the medication was not available. Review of the same record 24 hours later revealed several corrections related to the above examples, however, the corrections were not identified as late entry documentation.</p> <p>Interview on 05/25/11 at 10:40 AM with Licensed Practical Nurse (LPN) #2 revealed if a dose of medication was not given as ordered, the reason should be documented on the MAR by initialing the MAR to indicate the attempt to administer the dose of medication as ordered.</p> <p>Interview with the DON on 05/25/11 at 2:40 PM confirmed the late entry documentation changes had been made to the May 2011 MAR. Further interview revealed the facility procedure allowed staff up to 24 hours to document without it being identified as a late entry, however, the timeframe had expired for several corrections staff made to the May 2011 MAR for Resident #17.</p> <p>2. Review of Resident #17's May MAR also revealed the order, undated, "may change G-tube as needed if occluded, dislodged or encrusted" without a size noted for the replacement tube.</p> <p>Review of the Physician's Orders dated, 05/21/11 at 4:00 PM, revealed an order to change the G-tube using the size of eighteen french (18 Fr) with a ten (10) milliliter bulb. Further review</p>	{F 514}	<p>guidelines for timely &amp; accurate documentation in the medical record, to include accurate documentation on the back of the MAR/TAR if a dose of medication is not administered for any reason, documentation in the nursing progress notes &amp; notification of the nurse in charge if residents refused any care planned interventions so that the MD can be made aware. Any new licensed &amp; unlicensed nursing staff will receive this information during the orientation process.</p> <p>The Administrator, DON, ADON, Medical Records Director, &amp; Administrator were re-educated on 7/14/11 by the Facility RN Consultant on the facility's policy for completion of the monthly medical records audits &amp; use of the monthly chart audit QI form.</p> <p>To monitor facility performance to ensure the solutions are sustained through the QI process, daily QI audits will be conducted by the QI nurse or designee, Monday through Friday, of each resident's MAR, to include Resident #17 &amp; Resident #35, to verify that appropriate documentation is being completed to indicate medications and/or treatments, including documentation of gastrostomy tube changes, are being given/administered as ordered. Any</p>	

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{F 514}	<p>Continued From page 44</p> <p>revealed the order 05/21/11 at 4:15 PM to discontinue all previous G-tube orders. An additional order, dated 05/21/11 at 4:15 PM revealed the change to use a twenty french (20 Fr) tube with a ten (10) milliliter bulb for the size of the replacement G-tube.</p> <p>Review of the progress notes revealed the G-tube was changed on 05/21/11, however, it was not documented on the MAR.</p> <p>Interview on 05/25/11 at 9:30 AM with LPN #3 revealed when the G-tube was replaced/changed it should be documented on the MAR.</p> <p>Interview on 05/26/11 at 2:10 PM with LPN #2 revealed the order on the MAR would need to reflect the size needed for the G-tube replacement so the correct tube could be placed.</p> <p>3. Record review revealed Resident #36 was re-admitted to the facility on 05/16/11 following hospitalization for Congestive Heart Failure.</p> <p>A review of the Physician's Orders, dated 05/16/11, revealed an order for oxygen at two (2) liters per nasal cannula.</p> <p>Observation on 05/24/11 of Resident #36 at 2:00 PM and 3:00 PM revealed the resident was not receiving oxygen.</p> <p>Review of the Nursing Progress Notes, dated 05/24/11 at 2:19 PM, revealed nursing documentation which stated the resident was receiving oxygen at two (2) liters as a specific intervention to prevent decline/deterioration related his/her respiratory status.</p>	{F 514}	<p>discrepancies will be addressed as indicated including re-education of licensed staff as appropriate. Monthly medical records audits will be performed by the Medical Records Director using the facility's policy for auditing resident medical records. A copy of this audit will be given to the Administrator &amp; DON each month for identification &amp; correction of concerns identified.</p> <p>The results of these QI audits will be reviewed with the Administrator in the weekly QI committee meeting, consisting of the Administrator, DON, ADON, QI nurse, Treatment nurse and/or MDS nurses, where the results of these audits will be compiled &amp; assessed for trends by the committee &amp; actions taken based on these assessments. Trends &amp; the accompanying actions taken will be reviewed by the QI Executive committee monthly, consisting of the Administrator, DON, ADON, QI nurse, Treatment nurse, MDS nurses, Medical Director, and/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(F 514)	Continued From page 45  Interview with the Director of Nursing on 05/25/11 at 3:30 PM revealed there was an apparent communication failure that resulted in the nurses in charge of Resident #35's care being unaware for hours the resident had refused to use as the oxygen as ordered for most of the shift.  Interview on 05/25/11 at 2:36 PM with LPN Applicant #4 revealed she was unaware Resident #35 was not utilizing the oxygen on 05/24/11 for several hours and had refused to wear the oxygen despite when she charted at 2:19 PM on 05/24/11 resident receiving oxygen.	(F 514)		
(F 520) SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	(F 520)	F520 There has been a change in the nursing leadership of the facility. The DON resigned from the position on 5/26/11. An interim DON was assigned to the position pending the start date of the new DON. This new DON assumed the role on 7/5/11 to assist the Administrator with the oversight to ensure that the resident's needs are met.  Re-education was completed by the Facility RN Consultant on 6/22/11 & again on 7/14/11 with the Administrative Staff, including the DON, ADON, QI nurse, Treatment nurse, MDS nurses & Administrator stressing the use of the QI process to identify quality issues or concerns that have the potential for negatively affecting the residents and to develop & implement plans of action to correct these identified issues or concerns. Any new administrative nursing staff will receive this information during the orientation process. A QI review of all	

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{F 520}	<p>Continued From page 46</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective Quality Assurance (QA) Committee that was structured to identify quality issues with the potential for negatively affecting the residents, and failed to implement plans of action to correct identified deficient practices. In addition, there was no evidence the Committee implemented an effective action plan to ensure that the corrective actions related to deficiencies cited during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 were resolved, thus resulting in continued deficient practice in these areas.</p> <p>The facility failed to effectively utilize the QA Committee to implement an effective action plan, when the facility became aware that residents Comprehensive Plans of Care were not being revised to meet the residents individualized needs, and nursing care was not being provided in accordance with professional standards of practice.</p> <p>The facility also failed to ensure action plans developed for previous deficient practice were monitored to ensure the plans were being implemented. This was evidenced by the facilities non-compliance from the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11, in the areas of CFR 483.20</p>	{F 520}	<p>resident's progress notes for the past 30 days was completed by the DON, ADON, QI nurse, Treatment nurse &amp; MDS nurses on 6/17/11. The focus of this additional review was to identify any issues or concerns with the potential for having a negative impact on the resident that may not have been identified in the previous audits. Any issues identified in the audit as having the potential to have a negative impact on residents were corrected as indicated at the time of the audits.</p> <p>To monitor performance to ensure that solutions are implemented &amp; sustained, weekly QI meetings will continue to be held with the Administrator, DON, ADON, MDS nurses, QI nurse and other interdisciplinary team members as directed by the Administrator and/or DON, to address all areas of this plan of correction in addition to responses from resident &amp; family satisfaction surveys or from data collected during facility staff rounds. Any identified areas of concern will be immediately forwarded to the Facility Registered Nurse Consultant for additional guidance in developing a plan of action to correct these identified concerns through the QI process. Trends &amp; their accompanying actions will be reviewed by the QI Executive committee, consisting of the</p>		

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{F 520}	<p>Continued From page 47</p> <p>Resident Assessment, F-280 and CFR 483.20 Resident Assessment, F-281; although the facility deemed compliance on 05/12/11 for these deficiencies.</p> <p>The findings include:</p> <p>1. Based on interview and record review, it was determined the facility failed to have an effective system to ensure Comprehensive Plans of Care were revised. This is a repeat deficiency which was cited on the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 for CFR 483.20 Resident Assessment, F-280 at a S/S of a "J". This was related to the facility failing to revise the Comprehensive Plans of Care for sufficient interventions to prevent recurrence of Resident #1's aggressive behaviors towards Resident #2 and other residents.</p> <p>Review of the facility's Allegation of Compliance with a compliance date of 05/12/11 revealed the Director of Nursing (DON), Assistant DON, Minimum Data Set Coordinator, Treatment Nurse, Quality Improvement Nurse, and/or Facility Registered Nurse (RN) Consultant would read the Nurse's Notes, Nursing Shift Reports, and review the pink carbon copies of the Physician's Orders daily to identify any changes in condition. They would then review that Care Plan revisions have occurred for those residents and update the Care Plan as necessary.</p> <p>However, the facility failed to ensure the Comprehensive Plans of Care were revised for Resident #33 related to the resident's mobility status and transfer technique after the resident sustained a Fracture to the Left Knee on</p>	{F 520}	<p>Administrator, DON, ADON, QI nurse, Medical Director and any other person required to provide information pertinent to the reports being discussed at the Executive committee meeting with further action taken as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	

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(F 520)	<p>Continued From page 48</p> <p>05/21/11. In addition, the facility failed to ensure the Comprehensive Plan of Care was revised for Resident #34 after a Physician's Order was obtained to elevate the resident's left leg as much as possible until healed.</p> <p>Interview on 05/26/11 with the Facility Registered Nurse (RN) Consultant revealed Resident #33 was noted through the auditing process to need major Care Plan revisions and a Significant Change Minimum Data Set (MDS) after the Left Knee Fracture. She further stated the resident's Care Guide which was kept inside the resident's closet door for the aides to refer to, was revised related to the resident's transfer assistance needed. Further interview revealed the Care Guide was a part of the resident's Plan of Care. However, she stated the Comprehensive Plan of Care had not been revised to indicate the need for staff assistance with transfer. Further interview revealed the intervention for Resident #34 to elevate the left leg as per Physician's Order was not noted with auditing.</p> <p>2. Based on Interview and record review it was determined the facility failed to have an effective system to ensure nursing care was provided in accordance with professional standards of care. This was a repeat deficiency which was cited on the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 for CFR 483.20 Resident Assessment F-281 at a S/S of a "J". This was related to the facility failing to provide necessary care and services to Resident #6 when the resident had signs of choking.</p> <p>Review of the facility's Allegation of Compliance with a compliance dated of 05/12/11 revealed all</p>	(F 520)		

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(F 520)	<p>Continued From page 49</p> <p>licensed staff were re-educated from 05/04/11 through 05/09/11 by the DON and ADON on recognizing an acute episode, conducting an assessment and presenting the information to the physician in order for him/her to make decisions and instruct the nurse with further orders. Further review revealed the DON, ADON, RN Supervisor, and/or Facility RN Consultant would read the Nurse's Notes, pink carbon copies of Physician's Orders, and review the Medication Administration Records (MARS) daily to ensure any documented acute episodes were recognized, reported to the physician, and that physician's orders were followed.</p> <p>However, the facility failed to ensure nursing care was provided in accordance with professional standards of care for Resident #17. Resident #17 sustained a change in condition on 05/18/11, to include nausea and coughing up tube feeding which required suctioning the resident several times. Although the physician was notified of the change in condition and new orders were obtained, there was no documented evidence of thorough assessment and monitoring after the change in condition was noted related to the resident's intolerance of tube feeding and increased need for suctioning.</p> <p>Interview on 05/26/11 at 11:00 AM with the Facility RN Consultant revealed the Administrative Nurses and Nurse Consultants were looking at Nurse's Progress Notes for content, assessment, documentation and notification of the Physician. However, there was no documented evidence the facility had recognized the lack of monitoring and documentation after staff noted a change in</p>	(F 520)		
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{F 520}	<p>Continued From page 50</p> <p>condition for Resident #17 on 05/18/11 related to the resident's intolerance of tube feeding and increased need for suctioning.</p> <p>In addition, although observation on 05/24/11 of Resident #35 at 2:00 PM and 3:00 PM revealed the resident was not receiving oxygen, review of the Nurse's Progress Notes, dated 05/24/11 at 2:19 PM, revealed nursing documentation which stated the resident was receiving oxygen at two (2) liters</p> <p>Interview with the DON on 05/24/11 at 4:00 PM and 05/25/11 at 3:30 PM revealed there was a communication failure and the nurses in charge of Resident #35's care were unaware for hours the resident had refused to use the oxygen as ordered for most of the shift. This resulted in a delay in assessing Resident #35's oxygenation saturation and notification of his/her physician in regard to the resident refusing to wear oxygen as ordered.</p> <p>Interview on 05/26/11 at 4:00 PM with the Administrator revealed she was unaware until this Revisit Survey, that the Administrative Nurses were not auditing as thoroughly as they should have been.</p>	{F 520}		
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