

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

PRINTED: 03/27/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2012
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NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029
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F 000	INITIAL COMMENTS An abbreviated survey (KY #17918) was conducted on 03/08/12 through 03/13/12 to determine the facility's compliance with Federal requirements. KY #17918 was substantiated with deficiencies cited at the highest scope and severity of a "D."	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	F 157 Resident # 1 no longer resides in the facility. All residents in the facility have the potential to be affected. Education will be provided to all licensed nurses to ensure they are aware that the responsible party must be notified of any change of condition or new medication order. Additionally, all charts will be reviewed to ensure the face sheet is current and has a responsible party listed. This will be conducted by the Admissions Coordinator and/or Social Services Department. The 24-hour report on all three wings will be reviewed on a daily basis Monday through Friday along with all physician orders. Any residents with an identified change in condition and/or change in medication will have their charts reviewed by the Unit Managers and/or Director of Nursing Services to ensure the responsible party was notified. In the case of a cognitively intact	04/26/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deanne Mc Cormack, RN, DNS</i>	TITLE 4/5/12	(X6) DATE
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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 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy/procedure, it was determined the facility failed to promptly notify the resident's physician or interested family member when there was a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly or a decision to transfer or discharge the resident from the facility for one resident (#1), in the selected sample of three residents. The facility failed to notify the physician related to a change in the resident's condition on 01/11/12; on 01/27/12; and on 02/01/12. Additionally, the facility failed to notify the resident's family related to a change in Resident #1's condition or about changes to the resident's treatment on 01/05/12; on 01/10/12 and 01/11/12; on 01/14/12, 01/15/12, and 01/16/12; on 01/23/12; and on 02/01/12.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Condition Change of a Resident," revised 10/31/06, revealed a resident's change of condition is identified for proper treatment implementation. The physician is informed of a resident's events and/or change in resident's condition. Immediate notification is defined as the physician should be informed at the time the event occurs either directly or by pager. Non-immediate notification is defined as the physician should be informed of the problem or</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>resident who is their own responsible party, the resident will be informed of any medication changes or other information.</p> <p>A review of the 24 hour report and all physician orders will be reviewed daily Monday through Friday and the responsible party contacted to ensure they were made aware of any changes in the resident. This will be conducted by the Unit Managers and/or Director of Nursing Services. If family notification did not occur the nurse who failed to notify the family will have the appropriate level of Performance Improvement action.</p> <p>An audit will be completed by the Director of Nursing Services daily Monday through Friday times two weeks. If no problems with notification are identified, four residents' families from each wing who have had a change of condition or new medication order will be contacted on a weekly basis times four weeks. If no problems are identified at that point, then four residents'</p>	

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F 157	<p>Continued From page 2</p> <p>event during office hours and generally no later than the next regular office day. If a non-immediate event occurs on a weekend or holiday, good nursing judgement shall determine if the notification could wait until the next office day or should be made during the weekend or holiday. The nurse should not hesitate to contact the physician at any time for a problem that in their judgement requires immediate medical attention. A significant change is defined as a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is "self-limiting," impacts more than one area of the resident's health status and requires interdisciplinary review and/or revision of the care plan. Notify family member/responsible party of resident's condition.</p> <p>A record review revealed the facility admitted Resident #1 on 12/23/11 with diagnoses to include Right Lower Lobe Pulmonary Embolism, Chronic Abdominal Pain, Hypertension, Chronic Hepatitis C and Bipolar Disorder. A review of the admission Minimum Data Set (MDS), dated 12/30/11, revealed the resident had a Brief Interview of Mental Status (BIMS) score of "4." Further review revealed Resident #1 was severely cognitively impaired and was totally dependent on one to two staff for assistance with activities of daily living. The resident was assessed to experience severe pain frequently and was on scheduled pain medication and as needed (PRN) pain medication.</p> <p>A review of the nurse's notes, dated 01/05/12, revealed a physician's order was received related</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>families will be contacted monthly times two months to ensure notification occurred. All of the results of the monitoring will be taken to Performance Improvement Meetings monthly to ensure compliance.</p> <p>Completion date: 04/26/12.</p>	

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F 157	<p>Continued From page 3</p> <p>to abnormal lab results; however, there was no evidence the family was notified. An interview with Licensed Practical Nurse (LPN) #2, on 03/13/12 at 2:22 PM, revealed she did not document on the Change of Condition form whether or not she notified the family. She revealed she was expected to notify the family with any changes in the resident's condition, as well as any new physician's orders received. An interview with the Unit Manager (UM), on 03/13/12 at 6:45 PM, revealed she expected the staff to notify the family related to physician's orders regarding the labs.</p> <p>A review of the nurse's notes, dated 01/10/12, revealed the resident had three abraded areas to [his/her] left buttocks and had a temperature of 101.2 degrees Fahrenheit (F). The physician was notified; however, there was no evidence the family was notified. An interview with the UM, on 03/13/12 at 6:45 PM, revealed the nurse should have notified the family about the skin issues, the treatment ordered, and the increased temperature. With any changes in the resident, the nurse should notify the physician as well as the family.</p> <p>A review of the nurse's notes, dated 01/11/12 at 9:00 AM, revealed the resident was difficult to arouse and in a "deep sleep." There was evidence the facility notified the physician regarding an abnormal lab value for the resident; however, there was no documented evidence that the physician was made aware of the resident's change in condition related to being difficult to arouse. Additionally, the family was not notified of a change in the resident's condition. An interview with Registered Nurse (RN) #1, on 03/09/12 at</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>

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F 157	<p>Continued From page 4</p> <p>2:35 PM, revealed they were expected to notify the physician and the family regarding a change in any resident's condition. She reported the resident was lethargic since admission to the facility, and it was not unusual for the resident to be difficult to arouse. She stated the family should have been notified about the lab results and the physician's orders received.</p> <p>A review of the nurse's notes, dated 01/14/12, revealed the resident had a moderate amount of blood in his/her stool with a foul odor noted. There was no evidence the family was notified regarding this change in condition. An interview with LPN #1, on 03/10/12 at 5:02 PM, revealed she was supposed to notify the physician and the family with any changes in a resident's condition. She checked the face sheet to see which family member to notify for changes in a resident's condition. If there was not anyone listed on the face sheet, then she contacted the Director of Nursing Service (DNS) for instructions. The resident did have a change and LPN #1 did not notify the family about the foul odor to the stools. An interview with the UM, on 03/13/12 at 6:45 PM, revealed the nurse should have contacted the family about the change and about the physician's orders.</p> <p>A review of the nurse's notes, dated 01/15/12, revealed the nurse documented the results of the labs that were obtained and reported the results to the physician; however, there was no evidence the family was notified. An interview with LPN #1, on 03/10/12 at 5:02 PM, revealed she should have notified the family about the abnormal lab results and about the physician's orders.</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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F 157	<p>Continued From page 5</p> <p>A review of the nurse's notes, dated 01/16/12, revealed documentation of edema in the resident's extremities and the physician was notified with new orders received; however, there was no evidence the family was notified. An interview with LPN #2, on 03/13/12 at 2:22 PM, revealed she did not document on the Change of Condition form whether or not she notified the family. She stated she was expected to contact the family with any changes in the resident's condition.</p> <p>A review of the nurse's notes, dated 01/23/12, revealed the resident's lab results were reviewed with the physician and new orders were received; however, the family was not notified. An interview with RN #1, on 03/09/12 at 2:35 PM, revealed they were expected to contact the family and the physician with any changes in the resident. She stated the family should have been notified about the lab results and any new orders received.</p> <p>A review of the nurse's notes, dated 01/27/12 at 10:00 AM, revealed the resident was observed to be holding food in [his/her] mouth. The family was contacted; however, the physician was not notified. An interview with LPN #3, on 03/09/12 at 3:43 PM, revealed, looking back on the situation, she should have notified the physician about the resident holding food in [his/her] mouth. She stated she should notify the physician and the family with any change in the resident's condition.</p> <p>A review of the nurse's notes, dated 02/01/12 at 9:00 AM, revealed the resident was holding food in [his/her] mouth; however, the nurse did not notify the physician or the family regarding a change in the resident's condition. Additionally, it</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 157	<p>Continued From page 6</p> <p>was documented, on 02/01/12 at 8:00 PM, that the family was visiting the resident and was concerned about the resident's unresponsiveness. The family also inquired about Resident #1 having a feeding tube inserted. There was no evidence these concerns were reported to the physician at that time. An interview with the UM, on 03/13/12 at 6:45 PM, revealed she expected the nurse to contact the resident's physician related to the family's inquiries about having a feeding tube placed in the resident. An interview with Resident #1's primary care physician, on 03/13/12 at 2:03 PM, revealed he was not notified about the family's inquiry of a feeding tube for the resident.</p> <p>An interview with the UM, on 03/09/12 at 3:17 PM, and on 03/13/12 at 6:45 PM, revealed she covered Hall 1 and the the back half of Hall 3. Resident #1 resided on the back half of Hall 3. The staff looked at each resident's face sheet in the chart to find out about the resident's responsible party. The name listed on the face sheet was the person who was contacted with any change in condition or any change in treatment.</p> <p>A phone interview with the DNS, on 03/13/12 at 4:44 PM, revealed the facility staff were expected to notify the physician and the responsible party with changes in the resident's condition. The DNS stated Resident #1 was his/her own responsible party and she was notified by the Admission Coordinator that the family was pursuing guardianship. The facility was not presented with proof the family had guardianship or Power of Attorney (POA). The facility informed the resident about changes in treatments,</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 157	Continued From page 7 medications or lab results, even if he/she was cognitively impaired; however, if there was an emergency situation, the staff contacted the first person identified on the resident's face sheet.	F 157	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		