

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2010
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NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 811 EAST PARRISH AVENUE OWENSBORO, KY 42303
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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>An annual survey was conducted on 05/06-07/10, to determine the facility's compliance with Federal Regulatory Requirements. Deficiencies were identified with the highest S/S being a "D", 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,</p>	F 000		
F 156 SS=D		F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Carol Lynn RN BSN NHA CRAN Administrator Director Ext Care Services 5/27/10

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 156	<p>Continued From page 1</p> <p>including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and</p>	F 156		

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F 156	<p>Continued From page 2</p> <p>provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to inform the resident both orally and in writing regarding changes made to the resident's resuscitation status for one resident (#2), in the selected sample of 10. Resident #2 was admitted to the facility with an Advance Directive for a "Full Code" and to receive "Life Support". In the event of Cardio-Pulmonary Arrest.</p> <p>On 04/20/10 at 8:45 AM, a Registered Nurse (RN) #1 documented a phone order and flagged the resident's chart, changing the resident's resuscitation status to a "Do Not Resuscitate" (DNR), which meant the resident would not be resuscitated in the event of a cardio-pulmonary</p>	F 156	<p>Resident and wife state during interview with state surveyors that he wanted full code status. An order was given by MD #1 to DON. Full code status was immediately initiated, notifying all caregivers. Updated care plans, communication board, chart and sticker in resident room were changed to full code, according to MD order.</p> <p>Friday PM, May 7, MD#1 visited with resident, daughter and wife, with RN in attendance. MD#1 again discussed full code status vs. DNR status. Resident and wife stated to MD#1 that they were very confused by the questions asked by the state surveyor and did not understand what was being asked. The resident stated that his concern was pain control and being comfortable.</p> <p>See attached progress note written by MD#1 on resident #2. After further discussion with MD#1, resident and wife state he wants to be a DNR as initially ordered.</p> <p>Code status of current resident was audited to ensure that all were appropriate. A "Do Not Resuscitate" request form will be initiated upon admission to TCC. This form will be discussed with the resident and family member, signed by the resident, family member, as well as nurse/Social Services explaining the form. A signed copy will be placed on chart, and a signed copy given to resident. A copy of the TCC policy, "Do Not Resuscitate" will be given to each resident upon admission and a discussion of full code vs. DNR will be held with resident and family and documented by staff member who signs the form.</p>	6/21/10	

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F 156	<p>Continued From page 3</p> <p>arrest. The facility failed to ensure the change was based on the wishes of the resident and the resident was capable of making an informed decision, failed to ensure the resident voiced the wish to change the resuscitation status to the physician and ensure the resident was informed orally and in writing of the change.</p> <p>Findings include:</p> <p>Review of the facility's policy of "Withholding and Withdrawing Life Support", dated 10/14/08, revealed it was the right of each patient who possessed the capacity to make decisions regarding his/her health care to do so, including the withdrawal or withholding of resuscitative/life prolonging treatment. The decision of a competent patient and his/her physician to enter an order withholding or withdrawing resuscitative services, life prolonging treatment, or artificially provided nutrition or hydration shall be documented by the physician along with the order. The patient (resident) may revoke his/her request at any time. The decision must be communicated by the patient (resident) to the physician. Facility policy also stated that verbal or telephone orders were permitted, but should be signed by the physician within twenty-four (24) hours.</p> <p>A record review revealed Resident #2 was admitted to the facility with diagnoses to include Renal Cell Carcinoma with Nephrectomy (removal of kidney), Chronic Obstructive Pulmonary Disease (COPD), Myocardial Infarction (MI), Status Post left hip fracture with fixation, Gastrointestinal Bleed, Hypertension, and Anxiety.</p> <p>A review of admission orders revealed Resident</p>	F 156	<p>A "Do Not Resuscitate" request form will be implemented for all residents admitted to Transitional Care, or upon request of code status change from Full Code to Do Not Resuscitate by any current resident.</p> <p>MD will be contacted to receive order for DNR per resident request for DNR status after discussion between nurse/Social Services and resident/family occurs upon admission to Transitional Care.</p> <p>If current resident requests a code status change to DNR, nurse and another staff member will have discussion with resident/family. Nurse will review DNR request form, have it signed, leave copy with resident and place original on chart. The nurse will call MD to receive order for DNR.</p> <p>Service Line Educator will inservice all staff on how to appropriately discuss preference of code status with resident and use of DNR request form before June 20, 2010.</p> <p>Chart audits by MDS Coordinator will be conducted on 10 charts monthly x 3 months to ensure appropriate form is signed and on chart and appropriate MD order for DNR on chart.</p> <p>Walking rounds will be performed by clinical supervisor weekly x 4 then monthly x 2 to ensure that pt. assignment board is correct and the card with resident name above bed is the appropriate color to indicate DNR.</p> <p>Results of chart reviews and walking rounds will be reported quarterly to PI Committee and to staff at monthly unit meeting.</p>		

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NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 011 EAST PARRISH AVENUE OWENSBORO, KY 42303		
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F 156	<p>Continued From page 4</p> <p>#2 was a "Full Code" status, in which Cardio-Pulmonary Resuscitation (CPR) would be performed in the event of Cardiac/Pulmonary arrest. A review of the phone order, dated 04/20/10, noted received and recorded by RN #1, revealed changes to the resident's resuscitation status to a DNR. The order was not signed by the physician. There was no documented evidence the physician or nurse talked with the resident or a reason to support the decision to change the resident's resuscitation status.</p> <p>A review of the Minimum Data Set (MDS), dated 04/18/10, revealed Resident #2 was identified by the facility as alert and oriented with organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations. A review of the undated care plan revealed Resident #2 was a Full Code and had a Living Will.</p> <p>An interview, on 05/07/10 at 8:44 AM, with Resident #2 and his/her spouse revealed Resident #2 became upset when not informed of his/her condition. Resident #2 stated, "People talk about me and make decisions for me and it makes me mad". Resident #2 and spouse both stated he/she had a Living Will but, "I don't know what it says or have a copy of it". Resident #2 stated that no person had ever talked with him/her about a DNR order. He/she stated he/she was under the impression he/she would receive CPR in the event of another heart attack.</p> <p>An interview with the Director of Nursing (DON) on 05/06/10 at 10:15 AM revealed she was aware Resident #2 had a Living Will,</p>	F 156		

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F 156	<p>Continued From page 5</p> <p>An interview, on 05/07/10 at 10:33 AM, with RN #1 revealed she was unaware of why she received and documented the DNR order for Resident #2. She was unsure of who the physician was who called and gave her the phone order. RN #1 stated, "This was the wishes of the family". She thought the physician had 24 hours to sign the order, but was unsure. RN #1 stated "I assume that I asked him/her (the resident) if wanted to be a DNR and the resident said yes". RN #1 did not remember what or how the resident was informed. She stated, "I believe the resident told me he/she did not want to be resuscitated. I believe". RN #1 stated the policy and procedure to obtain an order for DNR status included "a call is made to the physician, then the resident is talked to, to clarify DNR status, and then we obtain the order from the physician". RN #1 stated a physician's signature was never obtained.</p> <p>An interview, on 05/07/10 at 11:00 AM, with Physician #1 revealed she called the facility and gave RN #1 an order for Resident #2 to be changed to a DNR status. The physician stated, "He did not want anything done but he wanted to be kept comfortable with pain medication". Physician #1 stated she did not sign the DNR order or document any progress notes regarding the order to change the resuscitation status. On 05/07/10 at 11:18 AM, Physician #1 spoke with the facility's DON and changed Resident #2's code status back to a "Full Code". An order was written in the resident's chart changing the code status without first consulting with the resident or family.</p> <p>An interview, on 05/07/10 at 11:55 AM, with Physician #2, the resident's primary physician,</p>	F 156			

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F 156	Continued From page 6 revealed Resident #2 was a Full Code on admission to the facility. Physician #2 stated he discussed the resident's DNR status with him/her many times. Physician #2 stated he was not aware of an order being given to the facility to change Resident #2's status to a DNR. Physician #2 stated, "I would say at this point the resident would still say he/she wanted to be a Full Code. I have never known him/her to say a definite yes to a DNR".	F 156		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure one resident (#5), in the selected sample of 10, was provided care in accordance with the plan of care. Resident #5 sustained a fall when a staff person failed to implement the plan of care and activate the safety alarm. Findings include: Resident # 5 was admitted to the facility on 04/28/10 with diagnoses to include Thrombocytosis and Pneumonia. He/she had been assessed on admission as high risk for falls and was placed on the Fall Prevention Protocol and an alarm for the bed and chair was implemented on the plan of care. An observation, on 05/06/07 at 11:35 AM,	F 282	Bed alarm on resident #5 was plugged in by staff member. Fall Risk assessment will be completed by nursing staff on admission and ongoing, as indicated. Care Plans for all residents identified as potential fall risks will be implemented and updated by nursing staff. All residents will be rounded on every 1-2 hours, according to policy. Staff who round will check bed alarm to ensure alarm is on and in proper position. Service Line Educator will inservice nursing staff on the purpose of intentional rounding, including ensuring that the bed alarm is on, as well as the need to turn alarm back on after any care is provided to resident before June 20, 2010. Chart reviews by MDS Coordinator will be conducted on 10 charts monthly x 3 months to ensure care plans are appropriate and documentation is present.	6/21/10

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F 282	<p>Continued From page 7</p> <p>revealed the resident was sitting in a chair by the bed with an over-bed-table in front of him/her. The resident was pleasant and soft spoken.</p> <p>An interview with Resident #5's family member at the time of the observation, revealed the facility had notified the family member of a fall sustained by Resident #5 earlier that day. The facility notified the family at approximately 4:30 AM and stated the safety alarm had not been placed back on the resident after care was provided, prior to the fall. The resident sustained a hematoma to the back of the head and a CT scan of the head had been completed.</p> <p>An interview with the Director of Nursing (DON) on 05/06/10 at approximately 4:25 PM, revealed the facility investigation revealed two staff, Certified Nurse Aide (CNA) #1 and Registered Nurse (RN) #4, had provided care for Resident #5, had disconnected the alarm due to the type of care provided and failed to reconnect and ensure the alarm was working when the care was completed. A short time later, the resident was found on the floor beside his/her bed and had a bump to the back of the head. The two staff members had been pulled from another area, but were well aware of the facility policy related to alarms and both were re-educated.</p> <p>An interview with RN #4, on 05/07/10 at approximately 10:10 AM, revealed she had assisted with a bed bath for Resident #5 and the alarm was disconnected during that care by the CNA. However, the alarm was not reconnected after the care was provided. RN #4 stated all staff were responsible for ensuring the alarms were in place and working any time they were in a resident's room, but she did not recall visualizing</p>	F 282	<p>Bed alarm on resident #5 was plugged in by staff member.</p> <p>Fall Risk assessment will be completed by nursing staff on admission and ongoing, as indicated.</p> <p>Care Plans for all residents identified as potential fall risks will be implemented and updated by nursing staff.</p> <p>All residents will be rounded on every 1-2 hours, according to policy.</p> <p>Staff who round will check bed alarm to ensure alarm is on and in proper position.</p> <p>Service Line Educator will inservice nursing staff on the purpose of intentional rounding, including ensuring that the bed alarm is on, as well as the need to turn alarm back on after any care is provided to resident before June 20, 2010.</p> <p>Chart reviews by MDS Coordinator will be conducted on 10 charts monthly x 3 months to ensure care plans are appropriate and documentation is present.</p>	6/21/10	

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F 282	Continued From page 8 the alarm after the care was provided to Resident #5. A review of the Detailed Summary Report, dated 05/06/10 at 3:11 AM, revealed Resident #5 had been provided a bed bath. Nursing notes, dated 05/06/10 at 5:50 AM, revealed documentation, "At approximately 3:45 AM the patient was found on the floor next to his/her bed. Had attempted to get out of bed to go to the bathroom and fell. The bed alarm had not been plugged back up after the CNA had given a bath". A review of the Post Fall Debriefing form, dated 05/06/10 at 4:45 AM, revealed "CNA did not plug bed alarm back up after giving patient a bath".	F 282	Walking rounds by clinical supervisor will be conducted on every resident who has a bed alarm weekly x 4, then monthly x 2 to ensure alarms are plugged in and in proper position. Results of audit will be reported to PI Committee quarterly and to staff at monthly unit meeting by manager.		

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 05/06/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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