

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

PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391		
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated/Partial Extended Survey investigating KY#00019413 and reinvestigating KY#00019252 was initiated on 11/28/12 and concluded on 12/14/12. KY#00019252 remained substantiated with no deficiencies. KY#00019413 was substantiated with deficiencies identified. Immediate Jeopardy was identified on 12/05/12 and was determined to exist on 11/05/12 with deficiencies cited at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-280; 42 CFR 483.25 Quality of Care, F-309; and 42 CFR 483.75 Administration, F-490 and F-520 at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F-309. The facility was notified of the Immediate Jeopardy on 12/05/12. Deficient practice was also identified at 42 CFR 483.20 Resident Assessment, F-271 and 42 CFR 483.25 Quality of Care, F-328 at a scope and severity of a "D".</p> <p>The facility failed to ensure Resident #37 received the necessary care and services as evidenced by failure to assess and recognize a change in the resident's condition. Interviews revealed the resident had puffiness and pain in the left hip area on 11/05/12. The facility failed to notify the Physician of the puffiness and pain in the left hip area. The facility failed to ensure continued assessment and monitoring of this area. Interviews with staff revealed the left hip area continued to be painful to the resident, and was observed by staff to have bruising in the area. The area proceeded to have bruising which became larger. According to interview with a Hospice Registered Nurse (RN) when she observed the left hip area on the morning of</p>	F 000			

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

TITLE

(X6) DATE

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

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F 000	Continued From page 1 11/08/12 the bruising extended from the left hip to the pubic area. There was no documented evidence by the facility that the Physician was notified of Resident #37's condition change until 11/09/12. The Physician was notified of the bruising to the left hip area at 10:00 AM on 11/09/12. An x-ray was ordered and obtained on 11/09/12, which revealed Resident #37 had a fractured left hip. An acceptable credible Allegation of Compliance (AOC), related to the Immediate Jeopardy, was received on 12/11/12. On 12/14/12, the State Agency verified the Immediate Jeopardy was removed on 12/11/12 as alleged, prior to exit, with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-280; 42 CFR 483.25 Quality of Care, F-309; and 42 CFR 483.75 Administration, F-490 and F-520 at a Scope and Severity (S/S) of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.	F 000			
F 157	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	F 157			

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F 157	<p>Continued From page 2</p> <p>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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to have an effective system in place to ensure the Physician was notified of a change in condition for one (1) of nineteen (19) sampled residents (Residents #37).</p> <p>Facility staff observed changes of condition to Resident #37's left leg/hip on 11/05/12, 11/07/12, and 11/08/12 but failed to notify the resident's Physician. On 11/05/12 documentation revealed Resident #37 had swelling/puffiness, redness to the left hip and pain with movement; however, there was no evidence the facility notified the</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>resident's physician. On 11/07/12, Resident #37 was exhibiting pain when repositioned and bruising was noted to the inner left thigh per staff interviews. Review of the Resident Progress Notes, dated 11/08/12, revealed Resident #37 had complained of pain and discomfort in left leg/, and the left foot turned inward and appeared shorter than the right leg. Record review and interview revealed no evidence the Physician was notified of the resident's change in condition until 11/09/12. An x-ray was obtained on 11/09/12 which revealed the resident had a left hip fracture.</p> <p>The facility's failure to ensure an effective system was in place to ensure Physician notification of a change in condition was likely to cause risk for serious injury, harm, or impairment or death. The Immediate Jeopardy was identified on 12/05/12, and determined to exist on 11/05/12. The facility was notified of the Immediate Jeopardy on 12/05/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 with the facility alleging removal of the Immediate Jeopardy on 12/11/12. The Immediate Jeopardy was verified to be removed on 12/11/12, prior to exiting the facility on 12/14/12, with remaining non-compliance at 42 CFR 483.10, Resident Rights, F-157 Notification of Changes with a Scope and Severity of "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure Physicians are notified of changes in residents' conditions.</p> <p>The findings include:</p>	F 157			

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F 157	Continued From page 4 Review of the facility's policy titled, "Condition Change of a Resident", revised date 10/31/06, revealed the Physician was to be informed of resident events and/or change in resident's condition". Continued review of the policy revealed the Physician should be informed at the time the event occurs either directly or by pager. Further review revealed the nurse should notify the Physician of clinical problems; if the attending Physician was unavailable the nurse was to notify the alternate Physician or the Medical Director. Review of Resident #37's medical record revealed the resident was admitted to the facility on 11/05/11 with diagnoses which included Alzheimer's Disease, Debility, Osteoporosis and Failure to Thrive and was admitted to Hospice on 09/18/12 with a diagnosis of Dementia. Review of a Significant Change Minimum Data Set (MDS) Assessment, dated 09/25/12, revealed the facility assessed the resident as severely cognitively impaired. Continued review of the MDS revealed the facility assessed the resident as requiring limited to extensive assist with his/her Activities of Daily Living (ADLs). Interview, on 11/28/12 at 5:10 PM, with State Registered Nursing Assistant (SRNA) #20 revealed when she worked 11/05/12, on the 3:00 PM to 11:00 PM shift, Resident #37 started "hollering" when the bed was raised while she and SRNA #23 were repositioning the resident. She indicated when she undid the resident's brief she noticed the resident's left hip was red, swollen and inflamed. Additional interview, on 12/10/12 at 3:30 PM revealed she told a nurse	F 157			

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F 157	<p>Continued From page 5</p> <p>(Licensed Practical Nurse (LPN) #26) of Resident #37's change of condition on 11/05/12.</p> <p>Record review of a Nursing Progress Note, dated 11/05/12 at 9:00 PM, revealed the resident complained of pain to the left hip/leg. Continued review revealed the left hip area was puffy, with no redness, no discoloration, and the lower extremities were equal in length. Further review revealed the nurse documented she called the Hospice Nurse. However, there was no documented evidence the nurse notified the Physician of the change in the resident's condition.</p> <p>Interview, on 11/29/12 at 8:30 PM, with LPN #26, revealed on 11/05/12 the SRNAs (SRNA #20 and SRNA #23) told her Resident #37 was complaining of pain while they were providing care. LPN #26 stated Resident #37 moaned while she assessed the resident and pain was noted in both legs; however, more in the left leg. She indicated there was no redness or warmth to the site. She stated she called Hospice regarding the changes; however, she did not call the Physician. LPN #26 stated she thought the process was to call Hospice and Hospice notified the Physician.</p> <p>Interview, on 12/05/12 at 10:23 AM, with the Advanced Practice Registered Nurse (APRN) related to the resident's change of condition on 11/05/12, revealed she would want to be notified if there was puffiness or swelling to the resident's left hip. However, record review revealed no documented evidence the Physician or the APRN were notified of the puffiness in Resident #37's left hip area or the pain in the resident's legs on 11/05/12.</p>	F 157			

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F 157	Continued From page 6 Interview, on 11/30/12 at 5:05 PM, with SRNA #20 revealed during the beginning of her 3:00 PM to 7:00 PM shift on 11/07/12 (two days after Resident #37 was noted to have red, swollen and inflamed hip) she and SRNA #29 noticed green/purple bruising approximately six (6) inches in length and a couple of inches wide to Resident #37's inner part of the resident's thigh and vaginal area while providing care. SRNA #20 stated the resident would "holler" when they repositioned him/her. She indicated she assumed the bruising had already been reported to the nurses because she was told it was found by day shift. SRNA #20 stated she did not tell the nurse the resident was in pain; however, she stated should have. Interview, on 11/30/12 at 5:40 PM, with SRNA #29 revealed when she and SRNA #20 went into the resident's room on 11/07/12 to change Resident #37, he/she was in pain if moved. She stated Resident #37 would grab at his/her hips to protect them. She stated she checked the resident's hip and observed discoloration, dark enough that it stood out. She indicated she reported to the nurse (LPN #26) that the resident was in a lot of pain; however, was not sure if she told the nurse about the discoloration. Interview, on 12/04/12 at 4:00 AM, with SRNA #30 revealed she worked 11:00 PM to 7:00 AM shift on 11/07/12 and 11/08/12. SRNA #30 stated on 11/07/12, Resident #37 seemed to be in more pain in the leg/hip area. She indicated the resident moaned more than usual and she could tell something was unusual Resident #37. The SRNA stated she reported this to LPN #26. However, record review revealed no documented	F 157			

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F 157	<p>Continued From page 7</p> <p>evidence the Physician was notified of this change in the resident's condition on 11/07/12.</p> <p>Interview, on 12/01/12 at 5:44 PM, with LPN #26 revealed she worked on 11/07/12 from 3:00 PM until 7:00 AM and did not observe Resident #37's hip area during the shift. The LPN stated the resident did not complain of pain and she did not recall the SRNAs reporting Resident #37 had any bruising or pain to the hip area during her shift.</p> <p>Interview, on 12/03/12 at 3:10 PM, with SRNA #26 revealed when she did a check and change on 11/08/12 on day shift she noticed the discolored area, which she had observed on 11/07/12, looked larger and darker. She stated it was more purplish and had doubled in size from about a nickel size to about the size of a silver dollar and the resident seemed to be in pain whenever he/she was moved. SRNA #26 stated SRNA #28 reported this information to the nurse.</p> <p>Interview, on 12/02/12 at 12:45 PM, with SRNA #28 revealed when working with SRNA #26 during the day shift 11/08/12 they noticed the resident had bruising to the inside thigh area of her left leg near the groin area and was unaware of any discoloration to the area before this time. She stated this was reported to the nurse, who she thought was LPN #9.</p> <p>Interview, on 11/29/12 at 3:15 PM, with LPN #9 revealed she did not assess Resident #37's left hip area on 11/08/12 and no one reported the discoloration to the left thigh area or that the resident was having pain. She indicated if the SRNAs had thought there had been a change in the resident's condition, or he/she was having</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>pain it should have been reported to her.</p> <p>Interview, on 11/29/12 at 2:00 PM, with SRNA #19 revealed while she and another SRNA were turning Resident #37 during the evening shift on 11/08/12 the resident yelled so they informed LPN #35.</p> <p>Interview, on 11/30/12 at 3:05 PM and on 12/06/12 at 2:30 PM, with LPN #35 revealed she assessed Resident #37's hip/thigh area on 11/08/12 related to a report of pain to the resident's left side. She stated there was bruising to the resident's vaginal area and left side and she observed one leg was shorter than the other. She contacted Hospice about the pain and bruising, but did not contact the Physician because calling the Physician was a judgement call. She was told in training if a resident was in Hospice she was supposed to call Hospice, but if Hospice did not called back she was to call the Physician. She stated if the Physician was contacted by Hospice she did not think she would have to notify the Physician also. Record review revealed no documented evidence the facility notified the Physician of the resident's change in condition on 11/08/12.</p> <p>Interview, on 12/05/12 at 10:23 AM, with the APRN, related to the resident's change of condition on 11/08/12, revealed she would expect to be notified if there was bruising on the hips/buttocks of any sort if it was significant whether a resident had Hospice or not. She stated that just because a resident had Hospice didn't mean "we don't treat them".</p> <p>Review of Resident #37's Nursing Progress Note,</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>dated 11/08/12 at 9:00 PM, revealed the resident complained of pain and discomfort in the left leg/hip area, Hospice was called and a new order for Motrin (a pain reliever) 400 milligrams (mg) every six (6) hours as needed was obtained. Continued review revealed Resident #37's outer left hip, back of left upper leg, and the front of the labia and left leg had discoloration noted and the resident's left foot was turned inward and appeared shorter than the right leg. However, there was no documented evidence the Physician was notified of the change in condition.</p> <p>Interview, on 12/06/12 at 11:05 AM, with LPN #37 revealed on the morning of 11/09/12 she assessed Resident #37 because of reported bruising and pain to the area. She stated during her assessment she observed bruising which was dark purple to the resident's left hip, groin, and "private" area. She stated the resident would cry out in pain anytime she was touched in that area. She stated she called the APRN and Hospice and got an order for an x-ray.</p> <p>Review of the x-ray report, dated 11/09/12, revealed Resident #37 had a left hip fracture.</p> <p>Interview, on 11/30/12 at 3:30 PM, with Unit Manager, regarding the Progress Note on 11/08/12 at 9:00 PM, revealed even if a resident was in Hospice, nurses were supposed to notify the Physician. She stated the facility was ultimately responsible for the resident.</p> <p>Interview, on 12/04/12 at 2:05 PM, with the Director of Nursing Services (DNS) revealed the Physician should have been notified if there was a change in a resident's condition. Continued</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>interview, on 12/11/12 at 12:20 PM, with the DNS revealed nurses should have conferred with Hospice regarding the changes in Resident #37's condition documented on 11/05/12 and 11/08/12 and then called the resident's Physician.</p> <p>Interview, on 12/14/12 at 7:15 PM, with the facility's Executive Director revealed there was a misunderstanding by the nurse, on Resident #37's change of condition identified on 11/05/12, related to Physician notification. She stated the nurse did not follow the facility's process she had been educated on when she didn't notify the Physician. She stated, in regards to the documented change of Resident #37's condition on 11/08/12 at 9:00 PM, the nurse notified Hospice; however, she should have also notified the Physician.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 that alleged removal of the IJ effective 12/11/12. Review of the AOC revealed the facility implemented the following:</p> <p>1) Head-to-toe skin assessments were performed on all residents from 12/05/12 through 12/06/12 by licensed nurses to identify any others with indication of any change of condition/puffiness, swelling or redness. Any notable findings were communicated to the attending Physician and responsible party. Notable findings included, but were not limited to, Pressure Ulcers, Arterial Ulcers, Diabetic Neuropathic Ulcers, Venous Insufficiency Ulcers, Surgical Wounds, Skin Tears, Lacerations, Abrasions, Bruises, Burns, Rashes, or a Lesion associated with bleeding, itching, burning,</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>puffiness or swelling, discoloration and/or raised skin areas. The findings were documented by the licensed nurse, and communicated to the Physician and family for further follow-up. The licensed nurse was responsible to document findings in the residents' medical record and the 24 hour report.</p> <p>2) On 12/05/12 and 12/06/12 facility licensed nurses conducted an audit that reviewed all current residents' progress notes and the 24 hour reports for the previous thirty (30) days (11/05/12 to current) to validate changes in resident condition were identified and addressed with the Physician and responsible party notification. This audit also included validating any changes in resident condition including updating the care plan.</p> <p>3) The Administrator (Executive Director) communicated the change in the process for Physician notification by the facility to Hospice on 11/30/12 and again on 12/03/12.</p> <p>4) Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour sift reports would be audited daily starting on 12/06/12 and ongoing by the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), or Quality Assurance (QA) Registered Nurse (RN), Monday through Friday; and by the Weekend Supervisor RN on Saturdays and Sundays for any residents with a change in condition to validate appropriate identification of changes in resident condition, notification of the Physician and responsible party, and care plan revision.</p>	F 157			

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F 157	<p>Continued From page 12</p> <p>5) Shift to shift report was observed daily on each unit beginning 12/10/12 and ongoing by the DNS, ADNS, QA Nurse, Unit Managers (UM), three (3) to eleven (11) Supervisor, Weekend Supervisor, RN Case Manager, District Clinical RN Consultant to validate proper use of the 24 hour report and follow-up to resident change in condition.</p> <p>6) The Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents was placed on the Treatment Administration Record (TAR) on all units 12/06/12 for quick reference for the nurses.</p> <p>7) On 12/04/12 the Staff Development Coordinator (SDC) initiated education with all facility licensed nursing staff related to change in condition of resident status. Inservice dates were 12/04/12, 12/05/12, 12/06/12 and ongoing until all facility clinical staff had received the education. Education was provided by the SDC, ADNS', three (3) to eleven (11) RN Supervisor, Weekend RN, DNS, or QA RN. No nursing staff would be allowed to work until they had received the education. The inservices included: Situation Background Assessment Recommendation/Request (SBAR) form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.</p> <p>8) A Performance Improvement Committee (PIC)</p>	F 157			

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F 157	<p>Continued From page 13</p> <p>meeting was held on 12/05/12 and again on 12/06/12. The Medical Director was notified of the Immediate Jeopardy via telephone and approved the plan developed by the PIC on 12/05/12. The PIC reviewed and approved the Allegation of Compliance (AOC). The PIC was to ensure validation of the AOC by: beginning 12/06/12, initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms, and shift to shift observations were being reviewed by the DNS, ADNS', QA RN, and/or Weekend Supervisor RN on Saturday and Sunday to identify issues, trends or patterns and take corrective action as necessary. The QA RN would be responsible to report trends from the audits to the weekly PIC committee for review and further recommendations. The PIC would create corrective action plans for any areas of concern identified on the audits. The PIC committee would meet weekly or more often as necessary until the facility had removed the Immediate Jeopardy. Once the Immediate Jeopardy was removed the facility would return to routine monthly PIC committee meetings.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>Review of the skin assessment forms revealed all facility residents had skin assessments performed from 12/05/12 through 12/06/12 by licensed nurses, except three (3) who refused and one (1) that was end of life. Audit review revealed newly identified areas were reported to the physician and responsible party.</p> <p>Record review revealed the facility performed the</p>	F 157			

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F 157	<p>Continued From page 14</p> <p>audits as identified on the facility's AOC: An audit of resident progress notes and the 24 hour reports for the last 30 days was performed on 12/05/12 - 12/06/12. Daily audits of Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports started on 12/06/12. Problems identified were given to the Unit Managers for follow-up. The Shift to Shift audits were initiated by the facility on 12/10/12.</p> <p>Observation of the Treatment Administration Record (TAR) on each unit revealed they had Guidelines for Physician Notification of Change of Condition/Clinical Problems in the front.</p> <p>Interview, on 12/13/12 at 11:05 AM, with the Staff Development Coordinator (SDC) revealed she had completed education with facility staff related to the SBAR form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.</p> <p>Interviews with licensed nursing staff on 12/12/12 at 11:50 AM with Licensed Practical Nurse (LPN) #40, at 3:00 PM with Registered Nurse (RN) #11, at 3:15 PM with LPN #13; on 12/14/12 (7:00 AM to 3:00 PM shift) at 9:50 AM with LPN #3, at 2:00 PM with LPN #9, at 2:17 PM with LPN #16, at 2:45 PM with LPN #32, at 2:53 PM with LPN #15; on 12/14/12 (3:00 PM to 11:00 PM shift) at 5:35 PM with LPN #2, at 6:00 PM with LPN #31; and,</p>	F 157			

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F 157	<p>Continued From page 15</p> <p>on 12/14/12 (11:00 PM to 7:00 AM shift) at 3:42 PM with LPN #19 and at 4:32 PM with LPN #38 revealed they were all aware the "Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents" was on the Treatment Administration Record (TAR); they had received education on the Situation Background Assessment Recommendation/Request (SBAR) form; the 24 hour report form; the alert charting system; notification of the Physician and responsible party; assessing residents for a possible hip fracture; the State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms; and after notification to Hospice for recommendations for a resident with a change in condition, that they were to then notify the Physician of the change in condition and obtain orders, then notify the family. All licensed nurses interviewed confirmed that the shift to shift reports were being audited by Unit Managers, Assistant Director of Nursing Services (ADNS), 3:00 PM to 11:00 PM Supervisor, Quality Assurance Registered Nurse, and Weekend Supervisor.</p> <p>Interview, on 12/12/12 at 10:05 AM with State Registered Nursing Assistants (SRNAs) #8 and #9; on 12/14/12 at 9:15 AM with SRNA #37, at 9:15 AM with SRNA #38, at 2:33 PM with SRNA #27, at 3:00 PM with SRNA #32, at 3:40 PM with SRNA #39, at 4:00 PM with SRNA #13, at 4:19 PM with SRNA #34, at 4:28 PM with SRNA #35, and at 5:15 PM with SRNAs #33 and #36 revealed they had all received education on the Stop and Watch form for communicating changes in residents' condition to the nurses. Interview, on 12/14/12 at 9:25 AM with LPN #39 and at 9:30 AM with LPN #16 revealed the SRNAs had</p>	F 157			

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F 157	<p>Continued From page 16</p> <p>received training on the Stop and Watch form.</p> <p>Interview, on 12/11/12 at 12:20 PM, with the Director of Nursing Services (DNS) revealed education had been performed with facility staff in regards to the "skin sheet", Stop and Watch form, 24 hour report form, and proper notification of the Physician and family. She stated nurses had been re-educated to confer with Hospice, and also notify the Physician and responsible party. An additional interview, on 12/14/12 at 5:00 PM, with the DNS revealed in the facility's daily clinical review they were monitoring: the notification of change to the Physician and family, care plan updates, 24 hour report forms, alert charting forms, condition change forms, and Stop and Watch forms. She stated any concerns were followed up on by the Unit Managers (UM). The DNS stated she ensured the UMs completed the follow up via another meeting at the end of the day. According to the DNS, shift reports were being audited every day. She stated the audits were to ensure nurses were utilizing the 24 hour report form, alert charting, and any Stop and Watch forms to ensure the following shift was updated on residents' condition changes.</p> <p>Interview, on 12/14/12 at 11:40 AM, with RN #10/Assistant Director of Nursing Services (ADNS) for A and B units, revealed she audited progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days, and also ensured the care plan was updated. In an additional interview with RN #10/ADNS at 5:20 PM revealed she had monitored the shift to shift reports to ensure nurses were utilizing the 24 hour report form, the</p>	F 157			

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F 157	<p>Continued From page 17</p> <p>alert charting form, and any Stop and Watch forms to ensure the oncoming shift was aware of any changes in residents' condition.</p> <p>Interview, on 12/14/12 at 2:00 PM, with RN #2/ADNS (for C and D units) revealed he had performed audits of progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days.</p> <p>Interview, on 12/14/12 at 6:15 PM with the Weekend Supervisor RN revealed he had audited shift to shift reports to ensure the 24 hour report form, the alert charting and any Stop and Watch forms were being utilized to pass on residents' condition changes to the oncoming shift. He stated he had performed audits of the Physician orders, SBAR forms, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports.</p> <p>Interview, on 12/14/12 at 6:10 PM, with the Medical Director revealed she had been notified of the Immediate Jeopardy by telephone and had approved the Allegation of Compliance (AOC) after discussion with the facility. She stated the Performance Improvement Committee (PIC) had been meeting weekly since the Immediate Jeopardy was identified and she was involved with these meetings.</p> <p>Interview, on 12/14/12 at 7:15 PM, with the ED and Quality Assurance (QA) RN revealed the Executive Director communicated the change in the process for Physician notification by the facility to Hospice. She stated Hospice had been educated that the facility's nurses would contact</p>	F 157			

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F 157	<p>Continued From page 18</p> <p>the Physician. The QA RN verified that audits were being performed as per the AOC, such as shift to shift report audits to ensure the 24 hour report form and alert charting information was being utilized. The QA RN indicated if audits were performed at shift change then the 24 hour report, alert charting, SBAR forms, and Stop and Watch forms were being audited to ensure a change in a resident's condition is being passed along. According to the QA RN, the results of all the audits on the 24 hour report form, SBAR form, alert charting form, condition change form, care plan updates, Physician orders, Physician and family notification, and Stop and Watch forms were taken to the morning clinical meeting and discussed. The QA RN stated if a problem was identified then staff were educated by the person doing the audit. The QA RN stated he reported the results of the audits and any trends to the weekly PIC meeting. The ED stated education was performed as per the AOC. She stated through the use of the new three (3) part SBAR form and Stop and Watch form that communication was now "shored" up. She stated staff had been educated to ensure a Stop and Watch form was filled out with any change in a resident's condition.</p> <p>An additional interview, on 12/14/12 at 8:00 PM, with the ED revealed the PIC had been meeting weekly. According to the ED, the PIC was performing what was indicated in the AOC (i.e. -validating the AOC by: reviewing initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms; and shift to shift observations were being reviewed to identify issues, trends or patterns and to take the corrective action as necessary).</p>	F 157			

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F 271	<p>Corrective action plans for any areas of concern identified on the audits would be implemented.</p> <p>483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE</p> <p>At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy it was determined the facility failed to ensure admission orders were obtained for oxygen for one (1) of nineteen (19) sampled residents. Resident #41 was re-admitted from the hospital to the facility and was observed to have oxygen in use on 12/05/12; however, the facility failed to ensure there was a Physician's order for or use of oxygen.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Oxygen Therapy", dated 08/31/12, revealed Oxygen therapy is the administration and delivery of oxygen at concentrations greater than ambient air with the intent of treating or preventing the symptoms and manifestation of hypoxia. Further review of the policy revealed Licensed Nurses and Respiratory Therapist should verify physician order.</p> <p>Review of Resident #41's medical record revealed an admission date of 10/31/12, and a readmission date of 12/04/12, with diagnoses which included Chronic Obstructive Pulmonary</p>	F 271			

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F 271	<p>Continued From page 20</p> <p>Disease (COPD) and Congestive Heart Failure (CHF). Review of the Admission Minimum Data Set (MDS) dated 11/07/12, revealed the facility assessed Resident #41 to have not required the use of oxygen in the previous fourteen (14) days. Further review of the MDS revealed the facility assessed Resident #41 to have a Brief Interview for Mental Status (BIMS) score of twelve (12).</p> <p>Record review revealed a Physician's order dated 11/28/12, for oxygen at two (2) liters per minute (LPM) per nasal cannula related to a decreased oxygen saturation level and shortness of air (SOA). Further review of the Physician's order dated 11/28/12, revealed an order to send Resident #41 to the hospital related to chills of a sudden onset.</p> <p>Continued record review revealed the resident was readmitted to the facility on 12/04/12 and assessed by a nurse. Review of the nurse's assessment, dated 12/04/12, revealed no documented evidence the resident required oxygen. Review of the Admission Orders revealed no documented evidence of an order for oxygen.</p> <p>Observation, on 12/11/12 at 3:14 PM, revealed the resident to have an oxygen concentrator in his/her room, with a nasal cannula on and the oxygen set on two (2) LPM.</p> <p>Observation, on 12/11/12 at 4:40 PM, revealed Resident #41 continued to be using oxygen at two (2) LPM. Interview, at the time of this observation, with the resident and his/her daughter revealed Resident #41 had been using oxygen continuously at the facility since his/her return from the hospital on 12/04/12.</p>	F 271			

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F 271	<p>Continued From page 21</p> <p>Interview, on 12/12/12 at 8:50 AM, with Occupational Therapist (OT) #1 revealed Resident #41 had oxygen since his/her readmission to the facility. Observation, of Resident #41 at the time of this interview with the OT, revealed during the resident to have oxygen in use at two (2) LPM per nasal cannula.</p> <p>Review of Physician's orders from 12/04/12 through 12/11/12 revealed no documented evidence of an order for Resident #41 to have oxygen in use. Review of a Physician's order dated 12/12/12, timed 9:00 AM revealed the Physician had been notified and an order had been obtained for oxygen at two (2) LPM per nasal cannula continuously to maintain the resident's oxygen saturation levels between eighty-eight (88) and one hundred (100) percent.</p> <p>Interview, on 12/12/12 at 9:30 AM, with State Registered Nursing Assistant (SRNA) #32 revealed she had observed Resident #41 using oxygen continuously since his/her return from the hospital. She stated the resident had not complained of being short of breath.</p> <p>Interview, on 12/12/12 at 3:28 PM, with SRNA #33 revealed Resident #41 had been using oxygen since his/her return from the hospital.</p> <p>Interview, on 12/12/12 at 4:40 PM, with LPN #31 revealed she had observed Resident #41 using oxygen since his/her return from the hospital. She stated she wasn't aware if he/she had an order for the oxygen. When asked if the resident should have an order, she stated, "yes". In an additional interview, on 12/12/12 at 7:35 PM, LPN</p>	F 271			

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F 271	<p>Continued From page 22</p> <p>#31 stated the resident's use of oxygen would be considered a change in condition and the Physician should have been notified. When asked without an order how would she know how many LPM to administer, LPN #31 stated "I guess you don't" know.</p> <p>Interview, on 12/12/12 at 3:33 PM, Respiratory Therapist (RT) #1 revealed he had observed Resident #41 using oxygen since his/her return from the hospital. He stated he had also observed Resident #41 in the facility's hallways with portable oxygen in use. The RT stated when he assessed Resident #41 on 12/12/12, he/she needed oxygen related to upon exertion the resident showed "signs of dyspnea" (shortness of breath) and cyanosis (bluish discoloration of the skin and mucous membranes caused by a lack of oxygen in the blood).</p> <p>Interview, on 12/12/12 at 1:12 PM, with the A Unit Manager (UM) revealed the facility didn't have an order for Resident #41's oxygen. The UM stated she was not aware of the resident using oxygen prior to 12/12/12. She stated the RT had evaluated the resident that morning and together they had determined Resident #41 required oxygen use and the Physician was notified and gave the order. She stated the Physician should have notified for order for oxygen if it was in use prior to the 12/12/12, 9:00 AM order.</p> <p>Interview, on 12/12/12 at 4:27 PM, with the Director of Nursing Services (DNS) revealed when a resident had oxygen in use there should be an order. She stated the Physician should have been notified and an order obtained for the oxygen. According to the DNS, if the oxygen</p>	F 271			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391		
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F 271	Continued From page 23 concentrator had remained in the resident's room, someone should have questioned why and notified the nurse who could have notified the Physician to obtain an order.	F 271			
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policy it was determined the facility failed to have an effective system to ensure the comprehensive plan of care was reviewed and revised for two (2) of nineteen (19)	F 280			

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F 280	<p>Continued From page 24</p> <p>sampled residents (Residents #37 and #41).</p> <p>The facility failed to update the care plan for Resident #37 after the resident was assessed on 11/05/12 for having pain and puffiness in the left hip area for interventions to include continued monitoring and assessment of the area to prevent further pain and ensure the resident received the appropriate care and services. Three days later, on 11/08/12, Resident #37 was assessed by the nurse with pain/discomfort in the left hip/leg area and discoloration to the left hip, back of the left leg, front of the labia, and inside of the left leg and the left foot was turned inward and the left leg being shorter than the right leg. Review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised related to the resident's change in condition other than an order to administer 400 milligrams Motrin every six hours as needed. On the morning of 11/09/12 Resident #37 was noted to have bruising which was dark purple to the resident's left hip, groin, and "private" area and the resident cried out in pain. The APRN was contacted and an order obtained for an x-ray which revealed Resident #37 had a left hip fracture. (Refer to F-157 and F-309)</p> <p>In addition, the facility failed to revise Resident #41's care plan after the resident was re-admitted to the facility and had oxygen in use.</p> <p>Based on the above findings it was determined the facility's failure to revise the Comprehensive Plan of Care to ensure staff were aware of residents' care needs was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 12/05/12,</p>	F 280			

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F 280	<p>Continued From page 25 and determined to exist on 11/05/12. The facility was notified of the Immediate Jeopardy on 12/05/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 with the facility alleging removal of the Immediate Jeopardy on 12/11/12. The Immediate Jeopardy was verified to be removed on 12/11/12, prior to exiting the facility on 12/14/12, with remaining non-compliance at 42 CFR 483.20, Resident Assessment F-280, with a Scope and Severity of "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure care plans are revised appropriately.</p> <p>The findings include:</p> <p>Review of facility policy titled "Comprehensive Plan of Care", revised date 08/31/12, revealed a Comprehensive Plan of Care was developed for each resident and was to be re-evaluated and modified as necessary to reflect changes in care, service, and treatment. Further review revealed the care plan was to be updated during the course of care delivery to reflect new problems or modify interventions as a result of a change of condition in a resident.</p> <p>Review of facility policy titled "Condition Change in a Resident", dated 10/31/06, revealed resident change of condition was identified for proper treatment implementation. The policy referenced three (3) times that the Care Plan should be updated with a change in condition. In addition, review of the Transmission-Based Precaution policy, dated 09/19/12, revealed once precautions</p>	F 280			

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F 280	<p>Continued From page 26</p> <p>are initiated, the care plan should be updated to reflect this status.</p> <p>Interview, on 12/10/12 at 3:00 PM, with the Minimum Data Set (MDS) Coordinator, regarding the care plan process, revealed the Comprehensive Care Plan is based on the MDS Assessment. She stated nursing staff were responsible for making changes/updates from one Comprehensive Assessment to the next. According to the MDS Coordinator, the care plan update would occur based on a change and the interventions already in place would determine what updates would be required.</p> <p>1. Record review revealed Resident #37 was admitted to the facility on 11/05/11 with diagnoses which included Alzheimer's Disease, Debility, Osteoporosis and Failure to Thrive and was admitted to Hospice on 09/18/12 to include a diagnosis of Dementia.</p> <p>Review of a Significant Change MDS, dated 09/25/12, revealed facility assessed the resident to be severely cognitively impaired. Further review of this MDS Assessment revealed the facility assessed the resident to require limited to extensive assistance with all Activities of Daily Living (ADLs). Review of Resident #37's Comprehensive Care Plan revealed a plan of care, dated 11/23/11, for extensive assistance with all Activities of Daily Living (ADLs) related to cognitive loss.</p> <p>Interview, on 11/28/12 at 5:10 PM, with State Registered Nursing Assistant (SRNA) #20 revealed she noticed Resident #37's left hip was red, swollen and inflamed on 11/05/12. Additional</p>	F 280			

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F 280	<p>Continued From page 27</p> <p>interview, on 12/10/12 at 3:30 PM revealed she told a nurse of Resident #37's change of condition on 11/05/12.</p> <p>Review of a Nursing Progress Note, dated 11/05/12 at 9:00 PM, revealed Resident #37 complained of pain to the left hip/leg. Continued review revealed the left hip area was puffy, with no redness, no discoloration, and the lower extremities were equal in length. The facility failed to revise the plan of care to include interventions for assessment and monitoring related to the resident's change in condition.</p> <p>Review of Resident #37's medical record revealed a Nursing Progress Note, dated 11/08/12 (three days later), that documented the resident complained of pain and discomfort in the left leg/hip. The Note stated Resident #37's outer left hip, back of left upper leg, and the front of the labia and left leg had discoloration noted and the resident's left foot was turned inward and appeared shorter than the right leg. Review revealed the Nurse documented she called Hospice and obtained a new order for Motrin (a pain reliever) 400 milligrams (mg) every six (6) hours as needed. However, there was no documented evidence the Comprehensive Care Plan was updated to include interventions for assessment and monitoring related to the resident's change in condition.</p> <p>Interview, on 12/06/12 at 11:05 AM, with LPN #37 revealed on the morning of 11/09/12 she assessed Resident #37 because of reported bruising and pain to the area. She stated during her assessment she observed bruising which was dark purple to the resident's left hip, groin, and</p>	F 280			

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F 280	<p>Continued From page 28</p> <p>"private" area and the resident would cry out in pain anytime she was touched in that area. She stated she called the APRN an order for an x-ray.</p> <p>Review of the x-ray report, dated 11/09/12, revealed Resident #37's had a left hip fracture.</p> <p>Interview, on 12/06/12 at 2:30 PM, with LPN #35 revealed care plans were supposed to be updated immediately when a change was identified. She indicated she was just off orientation and knew she was supposed to update the care plan on the resident's complaint of pain. However, she stated she did not think she needed to update the care plan with her assessment findings of the bruising on the resident's outer left hip, back of left upper leg, and the front of the labia, or the left leg or of one leg being shorter than the other.</p> <p>Interview, on 12/10/12 at 3:00 PM, with the Minimum Data Set (MDS) Coordinator revealed if a nurse assessed a resident to have pain, bruising, one foot turned inward, and one leg shorter than the other, the nurse should have revised the care plan to include this information. She stated based on the findings identified in the assessments, it would have been appropriate to revise the care plan to include an intervention to encourage the resident not to get up until they had further evaluation and treatment, such as an x-ray.</p> <p>Interview, on 12/11/12 at 12:20 PM, with the Director on Nursing Services revealed her expectation of the nurse, regarding the documented assessment findings of 11/05/12 and 11/08/12 would have been that the care plan</p>	F 280			

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F 280	<p>Continued From page 29</p> <p>was revised to include nursing intervention, such as, continued observations of the area. She stated the nurses should have contacted the Physician regarding their assessments and then revised the care plan.</p> <p>2. Review of Resident #41's medical record revealed an admission date of 10/31/12, and a readmission date of 12/04/12, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Review of the Minimum Data Set (MDS) dated 11/07/12 revealed the facility assessed Resident #41 to have not required oxygen use in the previous fourteen (14) days. Further review of the MDS revealed the facility assessed Resident #41 to have a Brief Interview for Mental Status (BIMS) score of twelve (12).</p> <p>Record review revealed a Physician's order dated 11/28/12, for oxygen at two (2) liters per minute (LPM) per nasal cannula related to a decreased oxygen saturation level and shortness of air (SOA). Review of the record revealed Resident #41 was sent out to the hospital for evaluation on 11/28/12 related to "sudden onset chills". Review revealed the resident had an oxygen saturation level of seventy-nine (79) percent and shortness of air (SOA). Continued record review revealed the resident was readmitted to the facility on 12/04/12 with no documented evidence of oxygen use on readmission. Review of the Admission Orders revealed no documented evidence of an order for oxygen.</p> <p>Observation, on 12/11/12 at 3:14 PM, on 12/11/12 at 4:40 PM, and on 12/12/12 at 8:50 AM, revealed Resident #41 to have oxygen in use</p>	F 280			

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F 280	<p>Continued From page 30</p> <p>per nasal cannula at two (2) liters per minute (LPM) via an oxygen concentrator.</p> <p>Interview, on 12/11/12 at 4:40 PM, with Resident #41 and his/her daughter revealed Resident #41 had been using oxygen continuously at the facility since his/her return from the hospital on 12/04/12.</p> <p>Interview, on 12/12/12 at 8:50 AM with Occupational Therapist (OT) #1 revealed Resident #41 used oxygen "all the time now".</p> <p>Interview, on 12/12/12 at 9:30 AM, with SRNA #32 revealed she had observed Resident #41 using oxygen continuously since his/her return from the hospital.</p> <p>Interview, on 12/12/12 at 3:28 PM, with SRNA #33 revealed Resident #41 had been using oxygen since his/her return from the hospital.</p> <p>Interview, on 12/12/12 at 4:40 PM, with LPN #41 revealed she had observed Resident #41 using oxygen since his/her return from the hospital. In an additional interview, on 12/12/12 at 7:35 PM, LPN #41 stated a care plan should have been developed for the resident's use of oxygen.</p> <p>Interview, on 12/12/12 at 3:33 PM, Respiratory Therapist (RT) #1 revealed he had observed Resident #41 using oxygen since his/her return from the hospital. He stated he had also observed Resident #41 in the facility's hallways with portable oxygen in use. The RT stated when he assessed Resident #41 on 12/12/12, he/she needed oxygen related to upon exertion the resident showed "signs of dyspnea" (shortness of breath) and cyanosis (bluish discoloration of the</p>	F 280			

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F 280	<p>Continued From page 31</p> <p>skin and mucous membranes caused by a lack of oxygen in the blood).</p> <p>Interview, on 12/12/12 at 5:58 PM, the Director of Nursing Services (DNS) revealed a care plan should have been developed with nursing interventions for Resident #41's oxygen use.</p> <p>Continued review of Resident #41's record revealed no documented evidence on the Comprehensive Care Plan of the resident's use of or need for oxygen use.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 that alleged removal of the IJ effective 12/11/12. Review of the AOC revealed the facility implemented the following:</p> <p>1) Head-to-toe skin assessments were performed on all residents from 12/05/12 through 12/06/12 by licensed nurses to identify any others with indication of any change of condition/puffiness, swelling or redness. Any notable findings were communicated to the attending Physician and responsible party. Notable findings included, but were not limited to, Pressure Ulcers, Arterial Ulcers, Diabetic Neuropathic Ulcers, Venous Insufficiency Ulcers, Surgical Wounds, Skin Tears, Lacerations, Abrasions, Bruises, Burns, Rashes, or a Lesion associated with bleeding, itching, burning, puffiness or swelling, discoloration and/or raised skin areas. The findings were documented by the licensed nurse, and communicated to the Physician and family for further follow-up. The licensed nurse was responsible to document findings in the residents' medical record and the</p>	F 280			

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F 280	Continued From page 32 24 hour report. 2) On 12/05/12 and 12/06/12 facility licensed nurses conducted an audit that reviewed all current residents' progress notes and the 24 hour reports for the previous thirty (30) days (11/05/12 to current) to validate changes in resident condition were identified and addressed with the Physician and responsible party notification. This audit also included validating any changes in resident condition including updating the care plan. 3) The Administrator (Executive Director) communicated the change in the process for Physician notification by the facility to Hospice on 11/30/12 and again on 12/03/12. 4) Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour sift reports would be audited daily starting on 12/06/12 and ongoing by the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), or Quality Assurance (QA) Registered Nurse (RN), Monday through Friday; and by the Weekend Supervisor RN on Saturdays and Sundays for any residents with a change in condition to validate appropriate identification of changes in resident condition, notification of the Physician and responsible party, and care plan revision. 5) Shift to shift report was observed daily on each unit beginning 12/10/12 and ongoing by the DNS, ADNS, QA Nurse, Unit Managers (UM), three (3) to eleven (11) Supervisor, Weekend Supervisor, RN Case Manager, District Clinical RN Consultant to validate proper use of the 24 hour	F 280			

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F 280	<p>Continued From page 33 report and follow-up to resident change in condition.</p> <p>6) The Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents was placed on the Treatment Administration Record (TAR) on all units 12/06/12 for quick reference for the nurses.</p> <p>7) On 12/04/12 the Staff Development Coordinator (SDC) initiated education with all facility licensed nursing staff related to change in condition of resident status. Inservice dates were 12/04/12, 12/05/12, 12/06/12 and ongoing until all facility clinical staff had received the education. Education was provided by the SDC, ADNS', three (3) to eleven (11) RN Supervisor, Weekend RN, DNS, or QA RN. No nursing staff would be allowed to work until they had received the education. The inservices included: Situation Background Assessment Recommendation/Request (SBAR) form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.</p> <p>8) A Performance Improvement Committee (PIC) meeting was held on 12/05/12 and again on 12/06/12. The Medical Director was notified of the Immediate Jeopardy via telephone and approved the plan developed by the PIC on 12/05/12. The PIC reviewed and approved the Allegation of Compliance (AOC). The PIC was to</p>	F 280			

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F 280	<p>Continued From page 34</p> <p>ensure validation of the AOC by: beginning 12/06/12, initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms, and shift to shift observations were being reviewed by the DNS, ADNS', QA RN, and/or Weekend Supervisor RN on Saturday and Sunday to identify issues, trends or patterns and take corrective action as necessary. The QA RN would be responsible to report trends from the audits to the weekly PIC committee for review and further recommendations. The PIC would create corrective action plans for any areas of concern identified on the audits. The PIC committee would meet weekly or more often as necessary until the facility had removed the Immediate Jeopardy. Once the Immediate Jeopardy was removed the facility would return to routine monthly PIC committee meetings.</p> <p>9) The District and/or Regional team would provide RN clinical oversight a minimum of three (3) days per week beginning the week of 12/02/12.</p> <p>10) The facility contracted an outside clinical consulting group on 11/20/12 to conduct onsite facility clinical oversight two (2) days per week beginning 12/02/12.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>Review of the skin assessment forms revealed all facility residents had skin assessments performed from 12/05/12 through 12/06/12 by licensed nurses, except three (3) who refused and one (1) that was end of life. Audit review</p>	F 280			

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F 280	<p>Continued From page 35</p> <p>revealed newly identified areas were reported to the physician and responsible party.</p> <p>Record review revealed the facility performed the audits as identified on the facility's AOC: An audit of resident progress notes and the 24 hour reports for the last 30 days was performed on 12/05/12 - 12/06/12. Daily audits of Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports started on 12/06/12. Problems identified were given to the Unit Managers for follow-up. The Shift to Shift audits were initiated by the facility on 12/10/12.</p> <p>Interview, on 12/13/12 at 11:05 AM, with the Staff Development Coordinator (SDC) revealed she had completed education with facility staff related to the SBAR form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.</p> <p>Interview, on 12/13/12 at 11:00 AM, with the Executive Director (ED), Vice President of Clinical Operations, Director of District Operations, Director of Nursing Services (DNS), Quality Assurance (QA) RN, and contracted Nurse Consultant revealed the District and/or Regional team would provide RN clinical oversight a minimum of three (3) days per week beginning the week of 12/02/12. In addition, the facility had contracted with an outside clinical consulting</p>	F 280			

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F 280	<p>Continued From page 36</p> <p>group on to conduct onsite facility clinical oversight two (2) days per week.</p> <p>Interviews with licensed nursing staff on 12/12/12 at 11:50 AM with Licensed Practical Nurse (LPN) #40, at 3:00 PM with Registered Nurse (RN) #11, at 3:15 PM with LPN #13; on 12/14/12 (7:00 AM to 3:00 PM shift) at 9:50 AM with LPN #3, at 2:00 PM with LPN #9, at 2:17 PM with LPN #16, at 2:45 PM with LPN #32, at 2:53 PM with LPN #15; on 12/14/12 (3:00 PM to 11:00 PM shift) at 5:35 PM with LPN #2, at 6:00 PM with LPN #31; and, on 12/14/12 (11:00 PM to 7:00 AM shift) at 3:42 PM with LPN #19 and at 4:32 PM with LPN #38 revealed they were all aware the "Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents" was on the Treatment Administration Record (TAR); they had received education on the Situation Background Assessment Recommendation/Request (SBAR) form; the 24 hour report form; the alert charting system; notification of the Physician and responsible party; assessing residents for a possible hip fracture; the State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms; and after notification to Hospice for recommendations for a resident with a change in condition, that they were to then notify the Physician of the change in condition and obtain orders, then notify the family. All licensed nurses interviewed confirmed that the shift to shift reports were being audited by Unit Managers, Assistant Director of Nursing Services (ADNS), 3:00 PM to 11:00 PM Supervisor, Quality Assurance Registered Nurse, and Weekend Supervisor.</p> <p>Interview, on 12/12/12 at 10:05 AM with State</p>	F 280			

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F 280	<p>Continued From page 37</p> <p>Registered Nursing Assistants (SRNAs) #8 and #9; on 12/14/12 at 9:15 AM with SRNA #37, at 9:15 AM with SRNA #38, at 2:33 PM with SRNA #27, at 3:00 PM with SRNA #32, at 3:40 PM with SRNA #39, at 4:00 PM with SRNA #13, at 4:19 PM with SRNA #34, at 4:28 PM with SRNA #35, at 5:15 PM with SRNAs #33 and #36 revealed they had all received education on the Stop and Watch form for communicating changes in residents' condition to the nurses. Interview, on 12/14/12 at 9:25 AM with LPN #39 and at 9:30 AM with LPN #16 revealed the SRNAs had received training on the Stop and Watch form.</p> <p>Interview, on 12/11/12 at 12:20 PM, with the Director of Nursing Services (DNS) revealed education had been performed with facility staff in regards to the "skin sheet", Stop and Watch form, 24 hour report form, and proper notification of the Physician and family. She stated nurses had been re-educated to confer with Hospice, however they were to notify the Physician and responsible party. In an additional interview, on 12/14/12 at 5:00 PM, with the DNS revealed in the facility's daily clinical review they were monitoring: the notification of change to the Physician and family, care plan updates, 24 hour report forms, alert charting forms, condition change forms, and Stop and Watch forms. She stated any concerns are followed up on by the Unit Managers (UM). The DNS stated she ensures the UMs complete the follow up via another meeting at the end of the day. According to the DNS, shift reports were being audited every day. She stated the audits were to ensure nurses were utilizing the 24 hour report form, alert charting, and any Stop and Watch forms to ensure the following shift was updated on</p>	F 280			

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F 280	<p>Continued From page 38 residents' condition changes.</p> <p>Interview, on 12/14/12 at 11:40 AM, with RN #10/Assistant Director of Nursing Services (ADNS) for A and B units, revealed she audited progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days, and also ensured the care plan was updated. In an additional interview with RN #10/ADNS at 5:20 PM revealed she had monitored the shift to shift reports to ensure nurses were utilizing the 24 hour report form, the alert charting form, and any Stop and Watch forms to ensure the oncoming shift was aware of any changes in residents' condition.</p> <p>Interview, on 12/14/12 at 2:00 PM, with RN #2/ADNS (for C and D units) revealed he had performed audits of progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days.</p> <p>Interview, on 12/14/12 at 6:15 PM with the Weekend Supervisor RN revealed he had audited shift to shift reports to ensure the 24 hour report form, the alert charting and any Stop and Watch forms were being utilized to pass on residents' condition changes to the oncoming shift. He stated he had performed audits of the Physician orders, SBAR forms, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports.</p> <p>Interview, on 12/14/12 at 6:10 PM, with the Medical Director revealed she had been notified of the Immediate Jeopardy by telephone and had</p>	F 280			

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F 280	<p>Continued From page 39</p> <p>approved the Allegation of Compliance (AOC) after discussion with the facility. She stated the Performance Improvement Committee (PIC) had been meeting weekly since the Immediate Jeopardy was identified and she was involved with these meetings.</p> <p>Interview, on 12/12/12 at 3:00 PM, with the Executive Director (ED) revealed the facility had good support from the Corporate level. She stated the facility had contracted with a consulting group that was coming two (2) days per week to help with problem solving. The ED stated the contracted consulting group and the Corporate level staff coming would provide training as necessary if problems were identified. She stated the Medical Director was very supportive and in communication very often and attended the Performance Improvement Committee (PIC) meetings monthly. According to the ED, she leads the PIC and it was continuously reviewing the problems identified.</p> <p>Interview, on 12/14/12 at 7:15 PM, with the ED and Quality Assurance (QA) RN revealed the Executive Director communicated the change in the process for Physician notification by the facility to Hospice. She stated Hospice had been educated that the facility's nurses would contact the Physician. The QA RN verified that audits were being performed as per the AOC, such as shift to shift report audits to ensure the 24 hour report form and alert charting information was being utilized. The QA RN indicated if audits were performed at shift change then the 24 hour report, alert charting, SBAR forms, and Stop and Watch forms were being audited to ensure a change in a resident's condition is being passed</p>	F 280			

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F 280	Continued From page 40 along. According to the QA RN, the results of all the audits on the 24 hour report form, SBAR form, alert charting form, condition change form, care plan updates, Physician orders, Physician and family notification, and Stop and Watch forms were taken to the morning clinical meeting and discussed. The QA RN stated if a problem was identified then staff were educated by the person doing the audit. The QA RN stated he reported the results of the audits and any trends to the weekly PIC meeting. The ED stated education was performed as per the AOC. She stated through the use of the new three (3) part SBAR form and Stop and Watch form that communication was now "shored" up. She stated staff had been educated to ensure a Stop and Watch form was filled out with any change in a resident's condition. An additional interview, on 12/14/12 at 8:00 PM, with the ED revealed the PIC had been meeting weekly. According to the ED, the PIC was performing what was indicated in the AOC (i.e. -validating the AOC by: reviewing initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms; and shift to shift observations were being reviewed to identify issues, trends or patterns and to take the corrective action as necessary). Corrective action plans for any areas of concern identified on the audits would be implemented.	F 280			
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309			

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F 309	Continued From page 41 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical well-being for one (1) of nineteen (19) sampled residents (Residents #37). Facility staff noted changes of condition to Resident #37's left leg/hip on both 11/05/12, 11/07/12, and 11/08/12. On 11/05/12 Resident #37 had swelling/puffiness, redness to the left hip and pain with movement; however, the facility's nurse failed to communicate the identified change in Resident #37 condition on the facility's 24 hour report to alert other staff. Interviews with facility staff revealed, on 11/07/12, the resident had a bruise like discolored area to the inner left thigh; however, staff failed to communicate this change with the nurse. On the morning of 11/08/12, a Hospice Nurse and Aide both noted Resident #37 had bruising from the left hip to the pubic area, but documentation revealed no assessment was completed by facility staff until 11/08/12 at 9:00 PM. At that time, it was documented Resident #37 had pain/discomfort to the left leg/hip, the left foot was turned inward and appeared shorter	F 309			

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F 309	<p>Continued From page 42</p> <p>than the right leg and there was discoloration to the outer left hip, back of left leg, front of labia, inside left leg. Further review of the documentation revealed the facility's nurse failed to document the findings on the facility's skin assessment sheet per the facility's process. Resident #37's Physician was not contacted until 11/09/12. An x-ray was ordered which revealed the resident had a fractured left hip.</p> <p>The facility's failure to ensure each resident received the necessary care and services related to assessing and identifying changes in residents' condition was likely to cause risk for serious injury, harm, or impairment or death. The Immediate Jeopardy was identified on 12/05/12, and determined to exist on 11/05/12. The facility was notified of the Immediate Jeopardy on 12/05/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 with the facility alleging removal of the Immediate Jeopardy on 12/11/12. The Immediate Jeopardy was verified to be removed on 12/11/12, prior to exiting the facility on 12/14/12, with remaining non-compliance at 42 CFR 483.25, Quality of Care, F-309 Necessary Care and Services, with a Scope and Severity of "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure assessments and recognition of changes in residents' conditions.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Condition Change of a Resident", revised 10/31/06,</p>	F 309			

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F 309	<p>Continued From page 43</p> <p>revealed the rationale was "resident change of condition is identified for proper treatment implementation". Review revealed the Physician was to be notified during office hours and generally no later than the next regular office day. Further review of the policy revealed licensed nurses were to monitor and reassess the resident's condition and update the care plan.</p> <p>Interview, on 12/04/12 at 2:05 PM, with the Director of Nursing Services (DNS) revealed the twenty-four (24) hour report was a communication tool for shift to shift reporting. She stated anyone could write on the report. According to the DNS, if there was a change of condition in a resident, it would be appropriate to put this information on the 24 hour report to alert staff to assess.</p> <p>Additional interview, on 12/11/12 at 12:20 PM, with the DNS revealed the facility also utilized a Stop and Watch form as a communication tool to report changes in residents. She stated the whole point of this form was to get ahead of an increased change in condition. The DNS indicated anyone could complete the form and the completed form was to be given to the nurse.</p> <p>Review of Resident #37's medical record revealed an admission date of 11/05/11 with diagnoses which included Alzheimer's Disease, Debility, Osteoporosis and Failure to Thrive and was admitted to Hospice on 09/18/12.</p> <p>Review of a Significant Change Minimum Data Set (MDS) Assessment, dated 09/25/12, revealed the facility assessed the resident as being severely cognitively impaired and required limited to extensive assistance with all Activities of Daily Living (ADLs).</p>	F 309			

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F 309	Continued From page 44 Interview, on 12/06/12 at 2:10 PM, with State Registered Nursing Assistant (SRNA) #19 revealed on 11/03/12 she observed Resident #37 sitting on the floor in the hallway and then pulling himself/herself off the floor using the rail and then the resident walked to his/her room. SRNA #19 stated she did not complete the Stop and Watch form related to this observation because she would only complete this form if she noticed a major change in the resident. In addition, she stated she did not document the episode on the 24 hour report; however, she stated she should have. Interview, on 11/28/12 at 5:10 PM, with SRNA #20 revealed on 11/05/12 she worked the 3:00 PM to 11:00 PM shift. She stated she went into Resident #37's room with SRNA #23 and was repositioning Resident #37 in bed when the resident started "hollering" when they moved his/her legs up. She indicated she undid the resident's brief and noticed the left hip was red, swollen and looked like it was inflamed. She indicated the resident did not complain of pain unless moved. According to SRNA #20, she was not aware of any falls and she told the nurse about what she had observed regarding the resident's hip area. Further interview, on 12/10/12 at 3:30 PM, revealed it would have been appropriate to have completed the Stop and Watch Form related to the change of condition; however, she stated she told the nurse instead of completing the form. Interview, on 11/29/12 at 8:00 PM, with SRNA #23 revealed on 11/05/12 she went into Resident #37's room and the resident moaned loudly when	F 309			

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F 309	<p>Continued From page 45</p> <p>his/her leg was moved but was not sure which leg. SRNA #23 indicated when the resident was changed at other times during her shift the resident would complain of pain. SRNA #23 stated she did not put this information on the 24 hour report form because they had told the nurse.</p> <p>Interview, on 12/03/12 at 5:10 PM, with SRNA #31 revealed she worked 11/05/12 on the 3:00 PM to 11:00 PM shift and was called into Resident #37's room by SRNA #20 to observe the resident. She stated when the resident's leg was raised he/she yelled out, which was unusual for the resident. She indicated she did not put this information on the 24 hour report. SRNA #31 stated this change should have been put on the 24 hour report.</p> <p>Record review of the Nurse's Progress Note, dated 11/05/12 at 9:00 PM, revealed the resident complained of pain to the left hip/leg and the resident's left hip area was puffy, had no redness, no discoloration and his/her lower extremities were equal in length. Review revealed the nurse called the Hospice Nurse.</p> <p>Interview, on 11/29/12 at 8:30 PM, with LPN #26 revealed on 11/05/12 the SRNA's came and told her the resident was complaining of pain. She stated when she assessed the resident pain was noted in both legs but more in the left leg and when the leg was moved the resident moaned. LPN #26 stated she gave the resident Tylenol and was not aware of any more complaints of pain. According to the LPN, she went back and checked the site at 10:00 PM and there was no change. LPN #26 stated she did not put her assessment findings on the 24 hour report, but</p>	F 309			

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F 309	<p>Continued From page 46</p> <p>"probably" should have. Further interview, on 12/05/12 at 2:30 AM, revealed the resident was in Hospice so she did not notify the Physician, because she had been instructed to call Hospice and notify them of any changes. The LPN stated she should have noted her assessment findings on the 24 hour report which was used to ensure follow-up of changes in condition.</p> <p>Further review revealed no documented evidence of the facility nurse's assessment of Resident #37's left hip area. Review of the facility's 24 Hour Report revealed no documented evidence related to Resident #37's change of condition on 11/05/12.</p> <p>Interview, on 11/30/12 at 3:30 PM, with the Unit Manager (UM), on the unit where the resident resided, revealed on 11/05/12 the LPN should have put the change of condition to Resident #37's left hip area on the 24 hour report. She stated without the information on the 24 hour report there would not have been a reason to assess the resident.</p> <p>Review of the Hospice On Call Nursing Record, dated 11/05/12 and timed 7:52 PM, revealed a phone call was received from the facility's nurse to report Resident #37's calf was hurting, but was not warm, red, or edematous. Review further revealed the facility's nurse also reported the resident was very active over the weekend and thought he/she was just sore.</p> <p>Interview, on 11/30/12 at 12:15 PM, with Hospice Nurse #3 revealed the facility nurse called on 11/05/12 and reported the resident's left calf was hurting and did not indicate any other problems.</p>	F 309			

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F 309	<p>Continued From page 47</p> <p>According to the Hospice Nurse, if she had been told the left hip was swollen she would have made a visit to assess the site to determine if further treatment was needed, such as, requesting an x-ray.</p> <p>Interview, on 12/05/12 at 10:23 AM, with the APRN related to the resident's change of condition on 11/05/12 revealed she would want to be notified if there was puffiness/swelling to the left hip.</p> <p>Interview, on 11/29/12 at 3:15 PM, with LPN #9 revealed she worked the morning of 11/06/12 and did not get a report of any change of condition to Resident #37. She stated, after reviewing the 11/05/12 Progress Note by LPN #26, the information should have been put on the 24 hour report. LPN #9 indicated the 24 hour report was used to communicate findings to all shifts. She stated if she had been made aware of a change of condition to the resident's left hip she would have assessed Resident #37's left hip area. Record review of the Nurse's Progress Notes for 11/06/12 revealed no documented evidence of any nursing assessment of the resident's left hip area.</p> <p>Interview, on 11/29/12 at 2:15 PM, with SRNA #27 revealed on the morning of 11/07/12, when they were getting the resident up for a shower the resident "hollered" and she noticed a small bruise on the resident's inner left thigh. SRNA #27 stated she told the nurse of the pain on the resident's left side, but when the nurse asked Resident #37 he/she denied pain.</p> <p>Interview, on 11/29/12 at 2:45 PM, with SRNA</p>	F 309			

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F 309	<p>Continued From page 48</p> <p>#26 revealed on the morning of 11/07/12, when they were transferring the resident for a shower he/she seemed to be in pain. She stated she noticed the resident had a small discolored area on the inner left thigh. According to the SRNA, the nurse and the Unit Manager came in to assess the resident.</p> <p>Interview, on 11/29/12 at 3:15 PM, with LPN #9 revealed on the morning of 11/07/12 she and the Unit Manager assessed Resident #37's left thigh. She indicated the left thigh had a small area of faint purple discoloration, it did not appear to be a bruise. LPN #9 stated it looked like spider veins. The LPN stated the resident denied pain and there was no swelling to the area. She stated she did not document this assessment anywhere and was unaware of any prior discoloration to the area.</p> <p>Interview, on 11/30/12 at 3:30 PM, with the Unit Manager (UM) revealed she observed Resident #37 with LPN #9 on 11/07/12 and assessed the upper left thigh area. She stated the resident's inner left thigh discoloration appeared to be like a Varicose Vein that was thin and elongated. The UM stated she was not aware of the area before this assessment. She indicated the resident had no complaints of pain and she had no concerns about the area at that time.</p> <p>Review of the Nurse's Progress Notes, dated 11/07/12, revealed no documented evidence related to the discolored area to the resident's inner left thigh observed by the SRNAs, LPN #9, and the UM.</p> <p>Interview, on 11/30/12 at 5:05 PM and on</p>	F 309			

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F 309	<p>Continued From page 49</p> <p>12/04/12 at 10:20 AM, with SRNA #20 revealed during the 3:00 PM to 7:00 PM shift on 11/07/12, she and SRNA #29 changed the resident at the beginning of the shift, and noticed bruising to the inner part of the thigh and vaginal area. The SRNA stated the area was green/purple in color and she estimated the area to be approximately six (6) inches in length and a couple of inches wide. She stated Resident #37 would "holler" when they repositioned him/her during the shift. SRNA #20 stated since the bruising was already there she assumed it had been reported to the nurse as she was told, in report by SRNA #26 and SRNA #27, it was found on day shift and had been reported to the nurse.</p> <p>Interview, on 11/30/12 at 5:40 PM, with SRNA #29 revealed she worked the evening of 11/07/12 with SRNA #20 and when they changed Resident #37, the resident was in pain when moved and Resident #37 grabbed at his/her hip. She indicated she observed discoloration to the resident's left inner thigh, dark enough that it stood out. She stated it looked like something that could have resulted from an injury. She stated she reported to the nurse that Resident #37 was in a lot of pain; however, was not sure if she told the nurse about the discoloration.</p> <p>Review of the facility's 24 Hour Report for 11/07/12 revealed no documented evidence of the pain or bruising to the resident's left inner thigh area observed by the SRNAs.</p> <p>Interview, on 12/04/12 at 4:00 AM, with SRNA #30 revealed she worked the 11:00 PM to 7:00 AM on 11/07/12 and 11/08/12. SRNA #30 stated on 11/07/12, Resident #37 seemed to be in more</p>	F 309			

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F 309	<p>Continued From page 50</p> <p>pain in the leg/hip and moaned more then usual. She stated she could tell something was unusual with the resident. SRNA #30 stated she reported this information to LPN #26.</p> <p>Interview, on 12/01/12 at 5:44 PM, with LPN #26 revealed she worked on 11/07/12 from 3:00 PM until 7:00 AM. She stated she did not observe the resident's hip area during her shift; however, had moved Resident #37's leg. LPN #26 stated the resident did not complain of pain and she did not recall the SRNAs reporting Resident #37 had any bruising or pain during the shift.</p> <p>Review of the Nurse's Progress Notes for 11/07/12 revealed no documented evidence of an assessment of the resident's left hip area for pain or discoloration.</p> <p>Review of the Hospice Certified Nursing Assistant (CNA) Visit Record, dated 11/08/12, revealed Hospice CNA #2 had visited the resident on from 8:30 AM to 9:30 AM. Review of the Visit Record revealed the CNA had reported to the Hospice Nurse that during Resident #37's bath she found bruising on the resident's vaginal area and on the inside of his/her thighs.</p> <p>Interview, on 11/30/12 at 1:50 PM, with Hospice CNA #2 revealed she had visited Resident #37 the morning of 11/08/12, to give him/her the regularly scheduled bath. She stated during the bath she noticed bruising all over the vaginal area and down the inside of the resident's thighs. According to the CNA, it was worse on the left side. She stated when she tried to turn the resident, he/she "moaned and groaned". The Hospice CNA indicated from her experience, the</p>	F 309			

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F 309	<p>Continued From page 51</p> <p>resident could have had a broken hip. She stated she reported her observations to Hospice Nurse #2 who came and looked at the area.</p> <p>Interview, on 12/06/12 at 11:15 AM, with Hospice Nurse #2 revealed she was called into Resident #37's room on the morning of 11/08/12, by the Hospice CNA. She stated she remembered seeing the bruise on the resident's left hip and pubic area. According to the Hospice Nurse, the resident did seem to have pain when moved. Hospice Nurse #2 did not recall moving the leg to assess. She stated she did not measure the area. She indicated she did talk to someone at the facility to see if the resident had fallen; however, she could not recall who she had spoken to.</p> <p>Interview, on 12/03/12 at 3:10 PM, with SRNA #26 revealed when she did a check and change on Resident #37, on 11/08/12 on day shift, she noticed the discolored area, she had observed on 11/07/12, looked larger and darker. She stated the area was more purplish and had doubled in size, from about a nickel to about the size of a silver dollar and the resident seemed to be in pain whenever moved. She stated another aide (SRNA #28) reported to the observations to the nurse.</p> <p>Interview, on 12/02/12 at 12:45 PM, with SRNA #28 revealed, when working with SRNA #26 on 11/08/12 on the day shift, she noticed the resident had bruising to the inside thigh area of her left leg near the groin. SRNA #28 stated she reported the finding to the nurse, whom she thought might have have been LPN #9.</p>	F 309		

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F 309	<p>Continued From page 52</p> <p>Interview, on 11/29/12 at 3:15 PM, with LPN #9 revealed she worked on 11/08/12 on the day shift and did not assess the resident's left hip site during her shift. She stated no one reported the discoloration to the left thigh area had changed or that the resident was having any pain problems and if the SRNAs had thought there had been a change or the resident was having pain it should have been reported to her so she could have assessed the area.</p> <p>Review of Resident #37's Progress Notes, dated 11/08/12 revealed no documented evidence of an assessment of the resident's left hip until 9:00 PM that night.</p> <p>Interview, on 11/29/12 at 2:00 PM, with SRNA #19 revealed she worked evening shift on 11/08/12, and Resident #37 yelled when she was turning the resident over. She stated she and another SRNA put the resident on his/her back and went to get LPN #35.</p> <p>Interview, on 11/30/12 at 3:05 PM, with LPN #35 revealed she assessed the resident's left hip area on 11/08/12 and noted there was bruising to the vaginal area and left side. She stated she did not complete a skin assessment related to her findings, however this was done the next day by another nurse. She indicated she assessed the area because of a report of pain to the resident's left side. She stated she contacted Hospice and let them know about the pain a bruising, however did not notify the Physician. Further interview, on 12/06/12 at 2:30 PM, revealed she had assessed one leg being shorter than the other during her assessment on 11/08/12. She indicated calling the Physician was a judgement call and she was</p>	F 309			

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F 309	<p>Continued From page 53</p> <p>told in training if the resident had Hospice staff were supposed to call Hospice. She stated in Hospice had not called back she would have called the Physician to report her assessment findings. According to the LPN, if the Physician was contacted by Hospice she did not think she would had to notify the Physician also.</p> <p>Interview, on 12/05/12 at 10:23 AM, with the APRN revealed she would expect to be notified if there was bruising on the hips/buttocks of any sort, if it was significant whether the resident was Hospice or not. She stated that just because a resident had Hospice didn't mean we don't treat them.</p> <p>Review of Resident #37's Progress Note, dated 11/08/12 at 2100, revealed the resident complained of pain and discomfort in the left leg/hip. Review revealed the nurse called Hospice and got a new order for Motrin (a pain reliever) 400 milligrams (mg) every six (6) hours as needed. The Note stated the resident's outer left hip, back of left upper leg, and the front of the labia and left leg had discoloration noted and the resident's left foot was turned inward and appeared shorter than the right leg. Review revealed the nurse called the Director of Nursing Services (DNS) and left a message.</p> <p>Review of the facility's 24 Hour Report revealed an entry on 11/08/12 for Resident #37 which noted a call to Hospice related to the resident being in a lot of pain and there being bruising to the labia, left hip, and inside the left leg. Review revealed a new order for Motrin (a pain reliever) 400 mg every six (6) hours as needed was obtained.</p>	F 309			

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F 309	Continued From page 54 Interview, on 11/30/12 at 3:30 PM, with the Unit Manager (UM) regarding the Progress Note on 11/08/12 at 9:00 PM revealed even if a resident has Hospice nurses were supposed to notify the Physician at the same time. She stated the facility was ultimately responsible for the resident. According to the UM, the nurse should have completed a non-pressure skin sheet related to her findings to give the area a baseline. Review of the Hospice On Call Nursing Record dated 11/08/12 and timed 10:51 PM, revealed Hospice received a phone call from the facility nurse who reported Resident #37 was having a lot of pain; that every time they touched the leg the resident cried. Review revealed the resident had a big bruise in the vaginal and groin area. Interview, on 11/20/12 at 12:00 PM, with Hospice Nurse #1 revealed she was informed by the facility nurse on 11/08/12, that Resident #37 had a large bruise to the groin and vaginal area, and the resident complained of pain when the left leg was moved. The Hospice Nurse stated she asked if the resident had fallen and the facility nurse indicated she was not aware of a fall. She stated the nurse did not mention one leg was shorter than the other; she just reported the bruising and pain and wanted to get pain medication. Continued interview, on 12/06/12 at 12:25 PM, with Hospice Nurse #1 revealed if the facility nurse had told her one of the resident's legs was shorter than the other, she would have immediately thought it was a hip fracture and would have went and assessed the resident. The Hospice Nurse indicated all she was told was that the resident was in pain. She stated she would	F 309			

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F 309	<p>Continued From page 55</p> <p>have requested an x-ray and pain medication stronger than Motrin.</p> <p>An additional interview, on 11/30/12 at 6:10 PM, with the Unit Manager (UM) revealed she did a skin assessment on 11/09/12 at 8:00 AM with LPN #37 because of an unrelated skin issue identified the night before. She stated she had noticed a non-pressure skin sheet was not completed as per facility process. According to the UM, this should have have been completed when the area was first identified. Additionally, the UM stated she inserviced LPN #35 regarding the lack of documentation in regards to the non-pressure skin sheet.</p> <p>Record review revealed a Nurse's Progress Note dated 11/09/12 at 8:00 AM, which indicated the resident had discoloration, pale purple/yellow starting at the center of the left pelvic region and extending downward into the pubic area.</p> <p>Interview, on 12/06/12 at 11:05 AM, with LPN #37 revealed on the morning of 11/09/12 she assessed Resident #37 because of reported bruising and pain to the left hip area. She stated when she assessed the resident she observed bruising to the resident's (left) hip, groin, and "private" area which was dark purple and the resident would cry out in pain anytime she was touched in that area. She indicated the the left foot had some slight rotation inward. She stated she called the APRN and the Hospice and got an order for an x-ray. The LPN stated whenever there was a change in a resident nurses were supposed to call the primary Physician and then call Hospice.</p>	F 309			

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F 309	<p>Continued From page 56</p> <p>Review of the x-ray report, dated 11/09/12, revealed Resident #37 had a left hip fracture.</p> <p>Interview, on 12/04/12 at 2:05 PM, with the Quality Assurance (QA) Nurse and the Director of Nursing Services (DNS) revealed SRNAs informed the nurse regarding a change of condition and the nurse would put it on the 24 hour report. The QA Nurse stated if pain was a new type of pain he would expect that to be documented on the 24 Hour Report. He stated if there were changes to the Resident #37's left thigh this should have been reported to the nurse and the nurse should have assessed the area. The DNS stated the 24 Hour Report was a communication tool for shift to shift reporting; anyone could document on the report. When asked about the documented condition change noted in the 11/05/12 progress note and related interviews, the DNS stated if there was a change in the condition of the area it would have been appropriate for staff to put on the 24 Hour Report to alert nursing staff to assess the site. She stated there should have been follow-up documentation of the area. The DNS also stated the MD should have been notified and the facility was ultimately responsible for the resident.</p> <p>Further interview, on 12/14/12 at 7:15 PM, with the QA Nurse revealed when any change in a resident was observed staff could complete the Stop and Watch form, the 24 Hour Report, and give verbal communication as well. He stated when the SRNAs observed changes to the resident on 11/05/12, 11/07/12 on the evening shift and 11/08/12 day shift, they should have completed a Stop and Watch form to notify the nurse of the changes. According to the QA</p>	F 309			

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F 309	<p>Continued From page 57</p> <p>Nurse, SRNAs had the ability to document on the 24 Hour Report; however it would have been more effective to take the nurse to the resident's room and point out the condition change. The QA Nurse indicated because these changes were not communicated to the nurse there was no monitoring of the area, and the Physician was not made notified of the changes in Resident #37's condition. Further interview revealed the facility nurse should have documented on the "skin sheet", the bruising identified on the 11/08/12 9:00 PM Nurse's Progress Note. In addition, he stated the care plan should have been updated accordingly with the nurse's findings on 11/05/12 and 11/08/12 at 9:00 PM.</p> <p>Continued interview, on 12/11/12 at 12:20 PM, with the DNS revealed staff did not monitor and assess the resident's changes in condition according to her expectation because for whatever reason staff did not utilize the communication tools available to alert other staff of the changes. She stated the documented changes identified on 11/05/12 should have been recorded on the 24 Hour Report to alert staff of the pain and puffiness. She indicated the bruising and pain to Resident #37's left hip/leg, reported by the aides on 11/07/12 and 11/08/12, should have been documented on the 24 Hour Report by the SRNAs. The DNS stated the SRNAs could also have utilized the Stop and Watch form, which had been in place for several months, that was another communication tool available to all staff to report changes. She stated the SRNAs should have completed the Stop and Watch form to communicate to the nurse the swelling and pain identified on 11/05/12, and the bruising and pain observed on</p>	F 309			

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F 309	<p>Continued From page 58</p> <p>11/07/12 and 11/08/12. According to the DNS, the nurses should have conferred with Hospice about the changes in condition documented on 11/05/12 and 11/08/12 and then notified the Physician of the changes. She stated the care plan should have been revised with interventions related to the 11/05/12 and 11/08/12 assessment findings of bruising and the resident's left leg appearing to be shorter than the right. She stated the nurse should have documented her assessment findings on a "skin sheet" for a baseline and completed an event report so the area would have been assessed and charted on for seventy-two (72) hours.</p> <p>Interview, on 12/14/12 at 7:15 PM, with the facility's Executive Director (ED) revealed there was a misunderstanding by the nurse related to Physician notification and documentation of Resident #37's change of condition identified on 11/05/12. She stated the nurse did not follow the facility's process she had been educated on. The ED stated the nurse didn't put the change in condition on the alert charting or 24 Hour Report or notify the Physician of the change. According to the ED, staff were supposed to put changes on the 24 Hour Report for follow-up. She stated no one monitored the area as it had not been placed on the 24 Hour Report. The ED stated that on 11/08/12 at 9:00 PM, the nurse notified Hospice of the change in Resident #37's condition, however should have also notified the Physician. In addition, she stated the nurse should have documented her assessment findings on the "skin sheet".</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 that</p>	F 309			

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F 309	<p>Continued From page 59</p> <p>alleged removal of the IJ effective 12/11/12. Review of the AOC revealed the facility implemented the following:</p> <p>1) Head-to-toe skin assessments were performed on all residents from 12/05/12 through 12/06/12 by licensed nurses to identify any others with indication of any change of condition/puffiness, swelling or redness. Any notable findings were communicated to the attending Physician and responsible party. Notable findings included, but were not limited to, Pressure Ulcers, Arterial Ulcers, Diabetic Neuropathic Ulcers, Venous Insufficiency Ulcers, Surgical Wounds, Skin Tears, Lacerations, Abrasions, Bruises, Burns, Rashes, or a Lesion associated with bleeding, itching, burning, puffiness or swelling, discoloration and/or raised skin areas. The findings were documented by the licensed nurse, and communicated to the Physician and family for further follow-up. The licensed nurse was responsible to document findings in the residents' medical record and the 24 hour report.</p> <p>2) On 12/05/12 and 12/06/12 facility licensed nurses conducted an audit that reviewed all current residents' progress notes and the 24 hour reports for the previous thirty (30) days (11/05/12 to current) to validate changes in resident condition were identified and addressed with the Physician and responsible party notification. This audit also included validating any changes in resident condition including updating the care plan.</p> <p>3) The Administrator (Executive Director) communicated the change in the process for</p>	F 309			

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F 309	<p>Continued From page 60</p> <p>Physician notification by the facility to Hospice on 11/30/12 and again on 12/03/12.</p> <p>4) Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour sift reports would be audited daily starting on 12/06/12 and ongoing by the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), or Quality Assurance (QA) Registered Nurse (RN), Monday through Friday; and by the Weekend Supervisor RN on Saturdays and Sundays for any residents with a change in condition to validate appropriate identification of changes in resident condition, notification of the Physician and responsible party, and care plan revision.</p> <p>5) Shift to shift report was observed daily on each unit beginning 12/10/12 and ongoing by the DNS, ADNS, QA Nurse, Unit Managers (UM), three (3) to eleven (11) Supervisor, Weekend Supervisor, RN Case Manager, District Clinical RN Consultant to validate proper use of the 24 hour report and follow-up to resident change in condition.</p> <p>6) The Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents was placed on the Treatment Administration Record (TAR) on all units 12/06/12 for quick reference for the nurses.</p> <p>7) On 12/04/12 the Staff Development Coordinator (SDC) initiated education with all facility licensed nursing staff related to change in condition of resident status. Inservice dates were 12/04/12, 12/05/12, 12/06/12 and ongoing until all facility clinical staff had received the education.</p>	F 309			

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F 309	<p>Continued From page 61</p> <p>Education was provided by the SDC, ADNS', three (3) to eleven (11) RN Supervisor, Weekend RN, DNS, or QA RN. No nursing staff would be allowed to work until they had received the education. The inservices included: Situation Background Assessment Recommendation/Request (SBAR) form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.</p> <p>8) A Performance Improvement Committee (PIC) meeting was held on 12/05/12 and again on 12/06/12. The Medical Director was notified of the Immediate Jeopardy via telephone and approved the plan developed by the PIC on 12/05/12. The PIC reviewed and approved the Allegation of Compliance (AOC). The PIC was to ensure validation of the AOC by: beginning 12/06/12, initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms, and shift to shift observations were being reviewed by the DNS, ADNS', QA RN, and/or Weekend Supervisor RN on Saturday and Sunday to identify issues, trends or patterns and take corrective action as necessary. The QA RN would be responsible to report trends from the audits to the weekly PIC committee for review and further recommendations. The PIC would create corrective action plans for any areas of concern identified on the audits. The PIC committee would meet weekly or more often as necessary</p>	F 309			

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F 309	<p>Continued From page 62</p> <p>until the facility had removed the Immediate Jeopardy. Once the Immediate Jeopardy was removed the facility would return to routine monthly PIC committee meetings.</p> <p>9) The District and/or Regional team would provide RN clinical oversight a minimum of three (3) days per week beginning the week of 12/02/12.</p> <p>10) The facility contracted an outside clinical consulting group on 11/20/12 to conduct onsite facility clinical oversight two (2) days per week beginning 12/02/12.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>Review of the skin assessment forms revealed all facility residents had skin assessments performed from 12/05/12 through 12/06/12 by licensed nurses, except three (3) who refused and one (1) that was end of life. Audit review revealed newly identified areas were reported to the physician and responsible party.</p> <p>Record review revealed the facility performed the audits as identified on the facility's AOC: An audit of resident progress notes and the 24 hour reports for the last 30 days was performed on 12/05/12 - 12/06/12. Daily audits of Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports started on 12/06/12. Problems identified were given to the Unit Managers for follow-up. The Shift to Shift audits were initiated by the facility on 12/10/12.</p>	F 309			

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F 309	<p>Continued From page 63</p> <p>Observation of the Treatment Administration Record (TAR) on each unit revealed they had Guidelines for Physician Notification of Change of Condition/Clinical Problems in the front.</p> <p>Interview, on 12/13/12 at 11:05 AM, with the Staff Development Coordinator (SDC) revealed she had completed education with facility staff related to the SBAR form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.</p> <p>Interview, on 12/13/12 at 11:00 AM, with the Executive Director (ED), Vice President of Clinical Operations, Director of District Operations, Director of Nursing Services (DNS), Quality Assurance (QA) RN, and contracted Nurse Consultant revealed the District and/or Regional team would provide RN clinical oversight a minimum of three (3) days per week beginning the week of 12/02/12. In addition, the facility had contracted with an outside clinical consulting group on to conduct onsite facility clinical oversight two (2) days per week.</p> <p>Interviews with licensed nursing staff on 12/12/12 at 11:50 AM with Licensed Practical Nurse (LPN) #40, at 3:00 PM with Registered Nurse (RN) #11, at 3:15 PM with LPN #13; on 12/14/12 (7:00 AM to 3:00 PM shift) at 9:50 AM with LPN #3, at 2:00 PM with LPN #9, at 2:17 PM with LPN #16, at 2:45 PM with LPN #32, at 2:53 PM with LPN #15;</p>	F 309			

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F 309	<p>Continued From page 64</p> <p>on 12/14/12 (3:00 PM to 11:00 PM shift) at 5:35 PM with LPN #2, at 6:00 PM with LPN #31; and, on 12/14/12 (11:00 PM to 7:00 AM shift) at 3:42 PM with LPN #19 and at 4:32 PM with LPN #38 revealed they were all aware the "Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents" was on the Treatment Administration Record (TAR); they had received education on the Situation Background Assessment Recommendation/Request (SBAR) form; the 24 hour report form; the alert charting system; notification of the Physician and responsible party; assessing residents for a possible hip fracture; the State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms; and after notification to Hospice for recommendations for a resident with a change in condition, that they were to then notify the Physician of the change in condition and obtain orders, then notify the family. All licensed nurses interviewed confirmed that the shift to shift reports were being audited by Unit Managers, Assistant Director of Nursing Services (ADNS), 3:00 PM to 11:00 PM Supervisor, Quality Assurance Registered Nurse, and Weekend Supervisor.</p> <p>Interview, on 12/12/12 at 10:05 AM with State Registered Nursing Assistants (SRNAs) #8 and #9; on 12/14/12 at 9:15 AM with SRNA #37, at 9:15 AM with SRNA #38, at 2:33 PM with SRNA #27, at 3:00 PM with SRNA #32, at 3:40 PM with SRNA #39, at 4:00 PM with SRNA #13, at 4:19 PM with SRNA #34, at 4:28 PM with SRNA #35, at 5:15 PM with SRNAs #33 and #36 revealed they had all received education on the Stop and Watch form for communicating changes in residents' condition to the nurses. Interview, on</p>	F 309			

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F 309	<p>Continued From page 65</p> <p>12/14/12 at 9:25 AM with LPN #39 and at 9:30 AM with LPN #16 revealed the SRNAs had received training on the Stop and Watch form.</p> <p>Interview, on 12/11/12 at 12:20 PM, with the Director of Nursing Services (DNS) revealed education had been performed with facility staff in regards to the "skin sheet", Stop and Watch form, 24 hour report form, and proper notification of the Physician and family. She stated nurses had been re-educated to confer with Hospice, however they were to notify the Physician and responsible party. In an additional interview, on 12/14/12 at 5:00 PM, with the DNS revealed in the facility's daily clinical review they were monitoring: the notification of change to the Physician and family, care plan updates, 24 hour report forms, alert charting forms, condition change forms, and Stop and Watch forms. She stated any concerns are followed up on by the Unit Managers (UM). The DNS stated she ensures the UMs complete the follow up via another meeting at the end of the day. According to the DNS, shift reports were being audited every day. She stated the audits were to ensure nurses were utilizing the 24 hour report form, alert charting, and any Stop and Watch forms to ensure the following shift was updated on residents' condition changes.</p> <p>Interview, on 12/14/12 at 11:40 AM, with RN #10/Assistant Director of Nursing Services (ADNS) for A and B units, revealed she audited progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days, and also ensured the care plan was updated. In an additional interview with</p>	F 309			

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F 309	<p>Continued From page 66</p> <p>RN #10/ADNS at 5:20 PM revealed she had monitored the shift to shift reports to ensure nurses were utilizing the 24 hour report form, the alert charting form, and any Stop and Watch forms to ensure the oncoming shift was aware of any changes in residents' condition.</p> <p>Interview, on 12/14/12 at 2:00 PM, with RN #2/ADNS (for C and D units) revealed he had performed audits of progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days.</p> <p>Interview, on 12/14/12 at 6:15 PM with the Weekend Supervisor RN revealed he had audited shift to shift reports to ensure the 24 hour report form, the alert charting and any Stop and Watch forms were being utilized to pass on residents' condition changes to the oncoming shift. He stated he had performed audits of the Physician orders, SBAR forms, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports.</p> <p>Interview, on 12/14/12 at 6:10 PM, with the Medical Director revealed she had been notified of the Immediate Jeopardy by telephone and had approved the Allegation of Compliance (AOC) after discussion with the facility. She stated the Performance Improvement Committee (PIC) had been meeting weekly since the Immediate Jeopardy was identified and she was involved with these meetings.</p> <p>Interview, on 12/12/12 at 3:00 PM, with the Executive Director (ED) revealed the facility had good support from the Corporate level. She</p>	F 309			

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F 309	<p>Continued From page 67</p> <p>stated the facility had contracted with a consulting group that was coming two (2) days per week to help with problem solving. The ED stated the contracted consulting group and the Corporate level staff coming would provide training as necessary if problems were identified. She stated the Medical Director was very supportive and in communication very often and attended the Performance Improvement Committee (PIC) meetings monthly. According to the ED, she leads the PIC and it was continuously reviewing the problems identified.</p> <p>Interview, on 12/14/12 at 7:15 PM, with the ED and Quality Assurance (QA) RN revealed the Executive Director communicated the change in the process for Physician notification by the facility to Hospice. She stated Hospice had been educated that the facility's nurses would contact the Physician. The QA RN verified that audits were being performed as per the AOC, such as shift to shift report audits to ensure the 24 hour report form and alert charting information was being utilized. The QA RN indicated if audits were performed at shift change then the 24 hour report, alert charting, SBAR forms, and Stop and Watch forms were being audited to ensure a change in a resident's condition is being passed along. According to the QA RN, the results of all the audits on the 24 hour report form, SBAR form, alert charting form, condition change form, care plan updates, Physician orders, Physician and family notification, and Stop and Watch forms were taken to the morning clinical meeting and discussed. The QA RN stated if a problem was identified then staff were educated by the person doing the audit. The QA RN stated he reported the results of the audits and any trends to the</p>	F 309			

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F 309	Continued From page 68 weekly PIC meeting. The ED stated education was performed as per the AOC. She stated through the use of the new three (3) part SBAR form and Stop and Watch form that communication was now "shored" up. She stated staff had been educated to ensure a Stop and Watch form was filled out with any change in a resident's condition. An additional interview, on 12/14/12 at 8:00 PM, with the ED revealed the PIC had been meeting weekly. According to the ED, the PIC was performing what was indicated in the AOC (i.e. -validating the AOC by: reviewing initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms; and shift to shift observations were being reviewed to identify issues, trends or patterns and to take the corrective action as necessary). Corrective action plans for any areas of concern identified on the audits would be implemented.	F 309			
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS 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. This REQUIREMENT is not met as evidenced	F 328			

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F 328	<p>Continued From page 69</p> <p>by: Based on observation, interview, record review and review of facility policy it was determined the facility failed to ensure one (1) of nineteen (19) sampled residents received proper treatment and care for special services. Resident #41 was re-admitted to the facility, on 12/04/12, and was noted by the Respiratory Therapist to have oxygen in use on 12/05/12; however, the facility failed to notify the Physician of the resident's need for oxygen and to obtain an order until 12/12/12. In addition, facility staff failed to assess and monitor the resident's oxygen use.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Oxygen Therapy", dated 08/31/12, revealed Oxygen therapy is the administration and delivery of oxygen at concentrations greater than ambient air with the intent of treating or preventing the symptoms and manifestation of hypoxia. Further review of the policy revealed Licensed Nurses and Respiratory Therapist should verify physician order and monitor the resident.</p> <p>Review of Resident #41's medical record revealed an admission date of 10/31/12, and a readmission date of 12/04/12, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Review of the Minimum Data Set (MDS) dated 11/07/12 revealed the facility assessed Resident #41 to have not required oxygen use in the previous fourteen (14) days. Further review of the MDS revealed the facility assessed Resident #41 to have a Brief Interview for Mental Status (BIMS) score of twelve (12).</p>	F 328			

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F 328	<p>Continued From page 70</p> <p>Review of the Physician's orders revealed the resident had an order dated 11/28/12, timed 11:30 AM to send Resident #41 to the hospital related to "sudden onset chills". Further review of this Physician's order revealed an order for oxygen per nasal cannula at two (2) liters per minute (LPM) related to an oxygen saturation level of seventy-nine (79) percent and shortness of air (SOA).</p> <p>Continued record review revealed the resident was readmitted to the facility on 12/04/12 and assessed by a nurse. Review of the nurse's assessment dated 12/04/12 revealed no documented evidence the resident required oxygen. Review of the Admission Orders revealed no documented evidence of an order for oxygen.</p> <p>Observation, on 12/11/12 at 3:14 PM, revealed the resident to have an oxygen concentrator in his/her room. Continued observation revealed Resident #41 to have a nasal cannula in place to his/her nares and the oxygen concentrator to be set on two (2) LPM.</p> <p>Observation, on 12/11/12 at 4:40 PM, revealed Resident #41 continued to have oxygen in use at two (2) LPM per nasal cannula. Interview, at the time of this observation, with the resident and his/her daughter revealed Resident #41 had been using oxygen continuously at the facility since his/her return from the hospital on 12/04/12.</p> <p>Observation on 12/12/12 at 8:50 AM, of Resident #41 during one of his/her therapy sessions revealed the resident to have oxygen in use at</p>	F 328			

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F 328	<p>Continued From page 71</p> <p>two (2) LPM per nasal cannula. Interview, at the time of this observation, with Occupational Therapist (OT) #1 revealed Resident #41 had not used oxygen prior to going out to the hospital, however used oxygen "all the time now". She stated the resident was alert and oriented and able to make his/her needs known.</p> <p>Continued review of Resident #41's medical record revealed no documented evidence the Physician was notified of the resident's need for oxygen. Review of Physician's orders from 12/04/12 through 12/11/12 revealed no documented evidence of an order for Resident #41 to have oxygen in use. Review of a Physician's order dated 12/12/12, timed 9:00 AM revealed an order had been obtained for oxygen at two (2) LPM per nasal cannula continuously to maintain the resident's oxygen saturation levels between eighty-eight (88) and one hundred (100) percent.</p> <p>Interview, on 12/12/12 at 9:30 AM, with State Registered Nursing Assistant (SRNA) #32 revealed she had observed Resident #41 using oxygen continuously since his/her return from the hospital. She stated he/she had not "said anything about being short of breath". According to SRNA #32 the resident used the oxygen all the time now.</p> <p>Interview, on 12/12/12 at 3:28 PM, with SRNA #33 revealed Resident #41 had been using oxygen since his/her return from the hospital.</p> <p>Interview, on 12/12/12 at 1:05 PM, with Licensed Practical Nurse (LPN) #15 revealed an order for Resident #41's oxygen had been obtained that</p>	F 328			

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F 328	<p>Continued From page 72</p> <p>morning by the A Unit Manager. She stated the resident had had an oxygen concentrator in his/her room, however had not used it. LPN #15 stated she had readmitted Resident #41 on 12/04/12 and he/she didn't have oxygen in use then. She stated he had the oxygen concentrator in his/her room "just in case" he/she needed it. When asked if she had observed or assessed Resident #41's oxygen use since his/her return from the hospital, she stated not that she could remember, unless she had "overlooked" it.</p> <p>Interview, on 12/12/12 at 4:40 PM, with LPN #41 revealed she had observed Resident #41 using oxygen since his/her return from the hospital. She stated she wasn't aware if he/she had an order for the oxygen. When asked if the resident should have an order, she stated, "yes". According to LPN #41, every time she had assessed Resident #41's oxygen saturation levels it had been "in the nineties". When asked if she had assessed or monitored Resident #41's oxygen use she stated "no". In an additional interview, on 12/12/12 at 7:35 PM, LPN #41 stated the resident's use of oxygen would be considered a change in condition. When asked without an order how would she know how many LPM to administer, LPN #41 stated "I guess you don't" know.</p> <p>Interview, on 12/12/12 at 3:33 PM, Respiratory Therapist (RT) #1 revealed he had observed Resident #41 using oxygen since his/her return from the hospital. He stated he had also observed Resident #41 in the facility's hallways with portable oxygen in use. When asked if he had assessed the resident for oxygen use, he stated he had not "until today" (12/12/12). The</p>	F 328			

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F 328	<p>Continued From page 73</p> <p>RT stated when he assessed Resident #41 on 12/12/12, he/she needed oxygen related to upon exertion the resident showed "signs of dyspnea" (shortness of breath) and cyanosis (bluish discoloration of the skin and mucous membranes caused by a lack of oxygen in the blood). He stated when the resident returned from the hospital he did not check the chart for an oxygen order. When asked without an order how would staff know what to set the resident's oxygen on, he stated "I guess he was on two (2) when he went out so the assumption was two (2) I guess".</p> <p>Interview, on 12/12/12 at 1:12 PM, with the A Unit Manager (UM) revealed the facility didn't have an order for Resident #41's oxygen. She stated the oxygen concentrator was left in the resident's room from his/her previous admission. The UM stated she was not aware of the resident using oxygen prior to 12/12/12. She stated the RT had evaluated the resident that morning and together they had determined Resident #41 required oxygen use. She stated there should have been an order for oxygen if it was in use prior to the 12/12/12, 9:00 AM order. In an additional interview, on 12/14/12 at 5:10 PM, with the UM revealed therapy felt like the resident required oxygen with exertion. She stated Resident #41 had not been on oxygen since his/her readmission until she had the RT assess the resident on 12/12/12 and he (RT) felt the resident needed oxygen.</p> <p>Interview, on 12/12/12 at 4:27 PM, with the Director of Nursing Services (DNS) revealed she could not recall seeing Resident #41 using oxygen prior to 12/12/12. She stated LPN #15 assessed the resident on readmission and talked</p>	F 328			

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F 328	Continued From page 74 to Resident #41's Physician. According to the DNS, the Physician did not give an order for oxygen at that time. She stated the Physician should have been notified and an order obtained, an SBAR form should have been completed, it should have been put on the twenty-four (24) hour report, the resident's responsible party should have been notified, and a care plan should have been developed with nursing interventions. When asked if staff should have been assessing and monitoring Resident #41's oxygen use, she stated "yes". According to the DNS, if the oxygen concentrator had remained in the resident's room someone should have questioned why and notified the nurse who could have notified the Physician.	F 328			
F 490	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility's Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident. The Administrator	F 490			

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

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F 490	<p>Continued From page 75</p> <p>failed to ensure the facility had an effective Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeat deficiencies related to the facility's failure to ensure the physician was notified with a significant change in residents' physical condition physical status and failure to fully assess and monitor residents' physical change in condition. This failure resulted in repeat noncompliance at 42 CFR 483.10 Resident Rights F-157 and 42 CFR 483.25 Quality of Care F-309.</p> <p>In addition, the Administration failed to have an effective system to ensure the Comprehensive Plans of Care were revised to include effective interventions in regards to assessing and monitoring of residents who experienced a change in condition. (Refer to F-280)</p> <p>On 11/05/12 Resident #37 was noted to have swelling/puffiness and redness to the left hip and pain with movement. There was no documented evidence the Physician was notified of this change in condition or that the plan of care was revised to ensure further assessment and monitoring. Interviews with facility staff revealed, on 11/07/12, the resident had a bruise-like discolored area to the inner left thigh however, failed to communicate this change to a nurse. On the morning of 11/08/12, a Hospice Nurse and Aide both noted Resident #37 had bruising from the left hip to the pubic area, however, review of facility documentation revealed no assessment or monitoring of the resident's change in condition by facility staff until 11/08/12 at 9:00 PM when Resident #37 was noted to have pain/discomfort</p>	F 490			

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F 490	<p>Continued From page 76</p> <p>to the left leg/hip, the left foot was noted to be turned inward and appeared shorter than the right leg and there was discoloration to the outer left leg, back of left leg, front of labia, and inside the left leg. The facility's administration failed to ensure that on 11/05/12 and 11/08/12 when facility staff noted changes of condition to Resident #37's left leg/hip that the resident's Physician was notified. The Physician was not notified until 11/09/12, when an x-ray revealed the resident had a left hip fracture.</p> <p>Based on the above findings it was determined the facility's failure to have an effective system in place to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 12/05/12 and determined to exist on 11/05/12.</p> <p>An acceptable credible Allegation of Compliance (AOC), related to the Immediate Jeopardy, was received on 12/11/12. On 12/14/12, the State Agency verified the Immediate Jeopardy was removed on 12/11/12 as alleged, prior to exit, with remaining non-compliance at 42 CFR 483.75 Administration, F-490 at a Scope and Severity (S/S) of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>(Refer to F-157) The facility failed to ensure the physician was notified of a significant change in a residents physical status. This was a repeat</p>	F 490			

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F 490	<p>Continued From page 77</p> <p>deficiency which was cited during a Standard Survey conducted 10/03/12 for deficiencies related to failure to notify the physician when a resident was noted to have a nodule in the vaginal area.</p> <p>During this survey, it was identified the facility failed to notify the physician changes of condition to Resident #37's left leg/hip beginning 11/05/12 through 11/08/12, until 11/09/12 when an x-ray revealed the resident had a left hip fracture.</p> <p>(Refer to F-280) The facility failed to ensure comprehensive plans of care were reviewed and revised when a change in condition was noted for Residents #37 and #41.</p> <p>The facility failed to update the care plan for Resident #37 after the resident was assessed on 11/05/12 for having pain and puffiness in the left hip area for interventions to include continued monitoring and assessment of the area to prevent further pain and ensure the resident received the appropriate care and services. Three days later, on 11/08/12, Resident #37 was assessed by the nurse with pain/discomfort in the left hip/leg area and discoloration to the left hip, back of the left leg, front of the labia, and inside of the left leg, and the left foot was turned inward and the left leg was noted being shorter than the right leg. Review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised related to the resident's change in condition other than an order to administer 400 milligrams Motrin every six hours as needed. On the morning of 11/09/12 Resident #37 was noted to have bruising which was dark purple to the resident's left hip, groin, and "private" area and</p>	F 490			

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F 490	<p>Continued From page 78</p> <p>the resident cried out in pain. The APRN was contacted and an order obtained for an x-ray which revealed Resident #37 had a left hip fracture.</p> <p>In addition, the facility failed to revise Resident #41's care plan after the resident was re-admitted to the facility and had oxygen in use. Also, the facility failed to revise Resident #2's care plan when he/she was placed in contact precautions after being diagnosed with a wound infection.</p> <p>(Refer to F-309) The facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical well-being for two (2) of forty-one (41) sampled residents (Residents #37 and #41) as evidenced by Resident #37 had a left hip fracture of unknown origin and Resident #41's use of oxygen upon re-admission from the hospital. This was a repeat deficiency for the facility which was cited during a Standard Survey conducted 10/03/12 for deficiencies related to failure to assess and monitor a resident after a nodule in the vaginal area was identified.</p> <p>Interview, on 12/14/12 at 3:00 PM, with the Administrator revealed the facility had been conducting audits of three skin assessments per unit per week to validate accuracy of skin assessments and documentation of these skin assessments to include appropriate physician and family notification. Further interview revealed these audits were turned into her, she reviewed them and problems had been identified and changes had been made since the compliance date of 10/30/12 from the survey ending 10/03/12. She stated the changes she had</p>	F 490			

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F 490	<p>Continued From page 79</p> <p>implemented included contracting with a consulting group on 11/20/12, to come to the facility two (2) days per week to help with problem solving. Continued interview revealed she implemented another new process in which she conducted walking rounds and had monitors go to each unit for thirty minutes. Further interview revealed these walking rounds would be used as teachable moments. According to the Administrator, she lead the PIC and it was continuously reviewing the problems identified. The administrator indicated the nurse on 11/05/12 did not follow the process for the MD notification and documentation she had been educated on as far as putting her assessment on the alert charting, 24 hour report, and notifying the Physician. She indicated when the nurse's findings were not on the 24 Hour Report, no one was aware to monitor the site.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 that alleged removal of the IJ effective 12/11/12. Review of the AOC revealed the facility implemented the following:</p> <p>1) Head-to-toe skin assessments were performed on all residents from 12/05/12 through 12/06/12 by licensed nurses to identify any others with indication of any change of condition/puffiness, swelling or redness. Any notable findings were communicated to the attending Physician and responsible party. Notable findings included, but were not limited to, Pressure Ulcers, Arterial Ulcers, Diabetic Neuropathic Ulcers, Venous Insufficiency Ulcers, Surgical Wounds, Skin Tears, Lacerations, Abrasions, Bruises, Burns, Rashes, or a Lesion</p>	F 490			

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F 490	<p>Continued From page 80</p> <p>associated with bleeding, itching, burning, puffiness or swelling, discoloration and/or raised skin areas. The findings were documented by the licensed nurse, and communicated to the Physician and family for further follow-up. The licensed nurse was responsible to document findings in the residents' medical record and the 24 hour report.</p> <p>2) On 12/05/12 and 12/06/12 facility licensed nurses conducted an audit that reviewed all current residents' progress notes and the 24 hour reports for the previous thirty (30) days (11/05/12 to current) to validate changes in resident condition were identified and addressed with the Physician and responsible party notification. This audit also included validating any changes in resident condition including updating the care plan.</p> <p>3) The Administrator (Executive Director) communicated the change in the process for Physician notification by the facility to Hospice on 11/30/12 and again on 12/03/12.</p> <p>4) Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour sift reports would be audited daily starting on 12/06/12 and ongoing by the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), or Quality Assurance (QA) Registered Nurse (RN), Monday through Friday; and by the Weekend Supervisor RN on Saturdays and Sundays for any residents with a change in condition to validate appropriate identification of changes in resident condition, notification of the Physician and responsible party, and care plan revision.</p>	F 490			

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F 490	Continued From page 81 5) Shift to shift report was observed daily on each unit beginning 12/10/12 and ongoing by the DNS, ADNS, QA Nurse, Unit Managers (UM), three (3) to eleven (11) Supervisor, Weekend Supervisor, RN Case Manager, District Clinical RN Consultant to validate proper use of the 24 hour report and follow-up to resident change in condition. 6) The Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents was placed on the Treatment Administration Record (TAR) on all units 12/06/12 for quick reference for the nurses. 7) On 12/04/12 the Staff Development Coordinator (SDC) initiated education with all facility licensed nursing staff related to change in condition of resident status. Inservice dates were 12/04/12, 12/05/12, 12/06/12 and ongoing until all facility clinical staff had received the education. Education was provided by the SDC, ADNS', three (3) to eleven (11) RN Supervisor, Weekend RN, DNS, or QA RN. No nursing staff would be allowed to work until they had received the education. The inservices included: Situation Background Assessment Recommendation/Request (SBAR) form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.	F 490			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	<p>Continued From page 82</p> <p>8) A Performance Improvement Committee (PIC) meeting was held on 12/05/12 and again on 12/06/12. The Medical Director was notified of the Immediate Jeopardy via telephone and approved the plan developed by the PIC on 12/05/12. The PIC reviewed and approved the Allegation of Compliance (AOC). The PIC was to ensure validation of the AOC by: beginning 12/06/12, initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms, and shift to shift observations were being reviewed by the DNS, ADNS', QA RN, and/or Weekend Supervisor RN on Saturday and Sunday to identify issues, trends or patterns and take corrective action as necessary. The QA RN would be responsible to report trends from the audits to the weekly PIC committee for review and further recommendations. The PIC would create corrective action plans for any areas of concern identified on the audits. The PIC committee would meet weekly or more often as necessary until the facility had removed the Immediate Jeopardy. Once the Immediate Jeopardy was removed the facility would return to routine monthly PIC committee meetings.</p> <p>9) The District and/or Regional team would provide RN clinical oversight a minimum of three (3) days per week beginning the week of 12/02/12.</p> <p>10) The facility contracted an outside clinical consulting group on 11/20/12 to conduct onsite facility clinical oversight two (2) days per week beginning 12/02/12.</p> <p>The State Survey Agency validated the</p>	F 490			

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F 490	<p>Continued From page 83 implementation of the facility's AOC as follows:</p> <p>Review of the skin assessment forms revealed all facility residents had skin assessments performed from 12/05/12 through 12/06/12 by licensed nurses, except three (3) who refused and one (1) that was end of life. Audit review revealed newly identified areas were reported to the physician and responsible party.</p> <p>Record review revealed the facility performed the audits as identified on the facility's AOC: An audit of resident progress notes and the 24 hour reports for the last 30 days was performed on 12/05/12 - 12/06/12. Daily audits of Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports started on 12/06/12. Problems identified were given to the Unit Managers for follow-up. The Shift to Shift audits were initiated by the facility on 12/10/12.</p> <p>Observation of the Treatment Administration Record (TAR) on each unit revealed they had Guidelines for Physician Notification of Change of Condition/Clinical Problems in the front.</p> <p>Interview, on 12/13/12 at 11:05 AM, with the Staff Development Coordinator (SDC) revealed she had completed education with facility staff related to the SBAR form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in</p>	F 490			

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F 490	<p>Continued From page 84 condition and notify family.</p> <p>Interview, on 12/13/12 at 11:00 AM, with the Executive Director (ED), Vice President of Clinical Operations, Director of District Operations, Director of Nursing Services (DNS), Quality Assurance (QA) RN, and contracted Nurse Consultant revealed the District and/or Regional team would provide RN clinical oversight a minimum of three (3) days per week beginning the week of 12/02/12. In addition, the facility had contracted with an outside clinical consulting group on to conduct onsite facility clinical oversight two (2) days per week.</p> <p>Interviews with licensed nursing staff on 12/12/12 at 11:50 AM with Licensed Practical Nurse (LPN) #40, at 3:00 PM with Registered Nurse (RN) #11, at 3:15 PM with LPN #13; on 12/14/12 (7:00 AM to 3:00 PM shift) at 9:50 AM with LPN #3, at 2:00 PM with LPN #9, at 2:17 PM with LPN #16, at 2:45 PM with LPN #32, at 2:53 PM with LPN #15; on 12/14/12 (3:00 PM to 11:00 PM shift) at 5:35 PM with LPN #2, at 6:00 PM with LPN #31; and, on 12/14/12 (11:00 PM to 7:00 AM shift) at 3:42 PM with LPN #19 and at 4:32 PM with LPN #38 revealed they were all aware the "Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents" was on the Treatment Administration Record (TAR); they had received education on the Situation Background Assessment Recommendation/Request (SBAR) form; the 24 hour report form; the alert charting system; notification of the Physician and responsible party; assessing residents for a possible hip fracture; the State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms; and</p>	F 490			

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F 490	<p>Continued From page 85</p> <p>after notification to Hospice for recommendations for a resident with a change in condition, that they were to then notify the Physician of the change in condition and obtain orders, then notify the family. All licensed nurses interviewed confirmed that the shift to shift reports were being audited by Unit Managers, Assistant Director of Nursing Services (ADNS), 3:00 PM to 11:00 PM Supervisor, Quality Assurance Registered Nurse, and Weekend Supervisor.</p> <p>Interview, on 12/12/12 at 10:05 AM with State Registered Nursing Assistants (SRNAs) #8 and #9; on 12/14/12 at 9:15 AM with SRNA #37, at 9:15 AM with SRNA #38, at 2:33 PM with SRNA #27, at 3:00 PM with SRNA #32, at 3:40 PM with SRNA #39, at 4:00 PM with SRNA #13, at 4:19 PM with SRNA #34, at 4:28 PM with SRNA #35, at 5:15 PM with SRNAs #33 and #36 revealed they had all received education on the Stop and Watch form for communicating changes in residents' condition to the nurses. Interview, on 12/14/12 at 9:25 AM with LPN #39 and at 9:30 AM with LPN #16 revealed the SRNAs had received training on the Stop and Watch form.</p> <p>Interview, on 12/11/12 at 12:20 PM, with the Director of Nursing Services (DNS) revealed education had been performed with facility staff in regards to the "skin sheet", Stop and Watch form, 24 hour report form, and proper notification of the Physician and family. She stated nurses had been re-educated to confer with Hospice, however they were to notify the Physician and responsible party. In an additional interview, on 12/14/12 at 5:00 PM, with the DNS revealed in the facility's daily clinical review they were monitoring: the notification of change to the</p>	F 490			

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F 490	<p>Continued From page 86</p> <p>Physician and family, care plan updates, 24 hour report forms, alert charting forms, condition change forms, and Stop and Watch forms. She stated any concerns are followed up on by the Unit Managers (UM). The DNS stated she ensures the UMs complete the follow up via another meeting at the end of the day. According to the DNS, shift reports were being audited every day. She stated the audits were to ensure nurses were utilizing the 24 hour report form, alert charting, and any Stop and Watch forms to ensure the following shift was updated on residents' condition changes.</p> <p>Interview, on 12/14/12 at 11:40 AM, with RN #10/Assistant Director of Nursing Services (ADNS) for A and B units, revealed she audited progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days, and also ensured the care plan was updated. In an additional interview with RN #10/ADNS at 5:20 PM revealed she had monitored the shift to shift reports to ensure nurses were utilizing the 24 hour report form, the alert charting form, and any Stop and Watch forms to ensure the oncoming shift was aware of any changes in residents' condition.</p> <p>Interview, on 12/14/12 at 2:00 PM, with RN #2/ADNS (for C and D units) revealed he had performed audits of progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days.</p> <p>Interview, on 12/14/12 at 6:15 PM with the Weekend Supervisor RN revealed he had audited</p>	F 490			

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F 490	<p>Continued From page 87</p> <p>shift to shift reports to ensure the 24 hour report form, the alert charting and any Stop and Watch forms were being utilized to pass on residents' condition changes to the oncoming shift. He stated he had performed audits of the Physician orders, SBAR forms, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports.</p> <p>Interview, on 12/14/12 at 6:10 PM, with the Medical Director revealed she had been notified of the Immediate Jeopardy by telephone and had approved the Allegation of Compliance (AOC) after discussion with the facility. She stated the Performance Improvement Committee (PIC) had been meeting weekly since the Immediate Jeopardy was identified and she was involved with these meetings.</p> <p>Interview, on 12/14/12 at 7:15 PM, with the ED and Quality Assurance (QA) RN revealed the Executive Director communicated the change in the process for Physician notification by the facility to Hospice. She stated Hospice had been educated that the facility's nurses would contact the Physician. The QA RN verified that audits were being performed as per the AOC, such as shift to shift report audits to ensure the 24 hour report form and alert charting information was being utilized. The QA RN indicated if audits were performed at shift change then the 24 hour report, alert charting, SBAR forms, and Stop and Watch forms were being audited to ensure a change in a resident's condition is being passed along. According to the QA RN, the results of all the audits on the 24 hour report form, SBAR form, alert charting form, condition change form, care plan updates, Physician orders, Physician</p>	F 490			

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F 490	Continued From page 88 and family notification, and Stop and Watch forms were taken to the morning clinical meeting and discussed. The QA RN stated if a problem was identified then staff were educated by the person doing the audit. The QA RN stated he reported the results of the audits and any trends to the weekly PIC meeting. The ED stated education was performed as per the AOC. She stated through the use of the new three (3) part SBAR form and Stop and Watch form that communication was now "shored" up. She stated staff had been educated to ensure a Stop and Watch form was filled out with any change in a resident's condition. An additional interview, on 12/14/12 at 8:00 PM, with the ED revealed the PIC had been meeting weekly. According to the ED, the PIC was performing what was indicated in the AOC (i.e. -validating the AOC by: reviewing initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms; and shift to shift observations were being reviewed to identify issues, trends or patterns and to take the corrective action as necessary). Corrective action plans for any areas of concern identified on the audits would be implemented.	F 490			
F 520	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.	F 520			

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F 520	<p>Continued From page 89</p> <p>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.</p> <p>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.</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 observation, interview, record review, and review of facility policy and the facility's plan of correction for the 10/03/12 standard survey it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to provide necessary care and services, and failure to ensure Physician notification. This failure resulted in continued noncompliance at 42 CFR 483.5 Resident Rights, F-157; 42 CFR 483.25 Quality of Care, F-309, and 42 CFR 483.75 Administration, F-520 at a scope and severity of a "J".</p>	F 520			

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F 520	<p>Continued From page 90</p> <p>The facility failed to ensure Resident #37 received the necessary care and services as evidenced by failure to assess and recognize a change in the resident's condition. Interviews revealed the resident had puffiness and pain in the left hip area on 11/05/12. The facility failed to notify the Physician of the puffiness and pain in the left hip area. The facility failed to ensure continued assessment and monitoring of this area. Interviews with staff revealed the left hip area continued to be painful to the resident, and the resident was observed by staff to have bruising in the area which changed in color and became larger. According to interview with a Hospice Registered Nurse (RN) when she observed the left hip area on the morning of 11/08/12 the bruising extended from the left hip to the pubic area. There was no documented evidence by the facility that the Physician was notified of Resident #37's condition change until 11/09/12 at 10:00 AM. An x-ray was ordered and obtained on 11/09/12, which revealed Resident #37 had a fractured left hip.</p> <p>The facility's failure to ensure each resident received the necessary care and services related to assessing, monitoring and identifying changes in residents' condition; the facility's failure to notify the physician of changes in residents' condition; and failure of the facility's Quality Assurance Program to effectively re-educate and monitor staff on communicating and notifying the Physician on resident changes of condition was likely to cause risk for serious injury, harm, or impairment or death. The facility was notified, on 12/05/12, of the Immediate Jeopardy at 42 CFR 483.10 Resident Rights (F157); 42 CFR 483.25 Quality of Care (F309); 42 CFR 483.75</p>	F 520			

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F 520	<p>Continued From page 91</p> <p>Administration (F490) and (F520) with Substandard Quality of Care in the area of 42 CFR 483.25 Quality of Care (F309). The Immediate Jeopardy was determined to exist on 11/05/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 prior to exiting the facility on 12/14/12, with the facility alleging removal of the Immediate Jeopardy on 12/11/12. The Immediate Jeopardy was verified to be removed on 12/14/12, prior to exiting the facility, with remaining non-compliance at 42 CFR 483.75, Administration, F-520 Quality Assurance, with a Scope and Severity of "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure the effectiveness of staff education, monitoring developed, and revisions to policies and procedures.</p> <p>The findings include:</p> <p>The facility's Quality Assurance Program failed to ensure the systemic changes noted on the acceptable Plan of Correction, for the 10/03/12 standard survey, were effective in ensuring compliance with F157 and F309 in regards to State Registered Nursing Assistants (SRNAs) communicating resident changes of condition, and licensed nurses notifying Physicians of changes in condition of a resident and related audits to monitor and assess changes in condition.</p> <p>The facility failed to ensure implementation of the "Condition Change of a Resident" policy; failed to ensure the Physician was notified of changes in</p>	F 520			

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F 520	<p>Continued From page 92</p> <p>residents' condition; and, facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical well-being. (Refer to F157, and F309).</p> <p>1. Based on observation, interview, and record review, it was determined the facility failed to ensure the Physician was notified of a change in Resident #37's condition. This was a repeat deficiency which was cited during a Standard and Abbreviated Survey conducted 09/17/12 through 10/03/12 related to failure to notify the Physician when a resident had an area/nodule in the vaginal area that changed in color and appearance.</p> <p>Review of the facility's Plan of Correction (POC), with a compliance date of 10/30/12, revealed the licensed nurses were re-educated related to performing head to toe skin assessments, with emphasis on notable findings that required Physician and family notification. State Registered Nursing Assistants (SRNAs) were educated to report changes resident conditions. In addition, notices were posted at each nursing station for SRNAs to immediately report any change in a resident's skin condition. Additionally, according to the POC, the progress notes were to be reviewed Monday through Friday for appropriate notification. The results of the audits were to be reported to Performance Improvement Committee (PIC) for four (4) weeks, then monthly thereafter.</p> <p>Record review and interview revealed facility staff had observed changes of condition in Resident #37's left leg and hip area from 11/05/12 through 11/08/12, however failed to effectively</p>	F 520			

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F 520	<p>Continued From page 93</p> <p>communicate these changes to other staff and failed to notify the Physician of the changes in the resident's condition. The Physician was notified on 11/09/12 and orders were received for an x-ray of the area. Review of the Radiology Report revealed the resident had a left hip fracture. (Refer to F-157)</p> <p>2. Based on observation, interview, record review and review of the facility policy the facility failed to have an effective system in place to ensure residents' received necessary care and services in regards to assessment and monitoring for one (1) resident (Resident #37) resulting in a repeat deficiency.</p> <p>Review of the facility's Plan of Correction (PoC), with a compliance date of 10/30/12, revealed five (5) SRNAs per week per unit for three (3) months were to be interviewed to validate new and/or unusual findings had been reported to the nurse, and that the nurse had appropriately assessed, documented, and made notification to the Physician and family. In addition, the Director of Nursing (DNS), Assistant Director of Nursing Services (ADNS), Staff Development Coordinator, would conduct an audit of three (3) skin assessments per unit per week for three months to validate skin assessment accuracy and one licensed nurse skin assessment would be observed weekly and documentation reviewed to determine accuracy and proper notification when appropriate. All weekly skin assessment documentation would be reviewed for one month to validate appropriate physician/family notification.</p> <p>Record review and interview revealed facility staff</p>	F 520			

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F 520	<p>Continued From page 94</p> <p>had observed changes of condition in Resident #37's left leg and hip from 11/05/12 through 11/08/12, however failed to assess and monitor these changes. Record review revealed an x-ray was obtained on 11/09/12 which indicated the resident had a hip fracture. (Refer to F-309).</p> <p>Interview, on 12/14/12 at 7:15 PM, with the Executive Director and the Quality Assurance Nurse revealed the when the nurses identified a change of condition, to Resident #37, they did not follow the facility's notification process to contact the Physician. They re-educated the nurses, when a change of condition was identified, to contact Hospice for recommendations and then contact the Physician. They have also informed Hospice of the change. The Executive Director further stated there was miscommunication. The nurse on 11/05/12 did not put the information regarding the resident's change of condition on the alert charting or the 24 hour report to communicate to other staff to follow-up. The Quality Assurance Nurse reported when the aides noted changes to Resident #37, left leg/hip area and increased pain, on 11/07/12 and 11/08/12 they should have completed the Stop and Watch form, written the findings on the 24 hour report, or they should have brought the nurse to the resident and pointed it out. Because this was not done, the site was not monitored (assessed) by the nurses and the Physician was not made aware. Further interview with the Quality Assurance Nurse revealed to prevent re-occurrence the facility put in place a shift to shift report audit to ensure nurses used the 24 hour report and alert charting for any resident condition change. In addition, the shift audit looked at alert charting documentation and if the</p>	F 520			

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F 520	<p>Continued From page 95</p> <p>SBAR form and Stop and Watch forms were utilized. At the morning clinical meetings they continued the audit process, by review of the 24 hour report sheet, alert charting, condition change forms, any care plan revisions, Physician Orders, the SBAR and Stop and Watch forms, and was proper notification completed if changes were identified. If problems were identified the person who performed the audit would re-educate staff and the expectation was it was corrected that day. The Unit Managers follow-up and report back at the PM meeting. The audit data was reviewed to identify problems/problematic trends and the results reported at the weekly Performance Improvement meeting and the monthly Quality Assurance Meeting.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/11/12 that alleged removal of the IJ effective 12/11/12. Review of the AOC revealed the facility implemented the following:</p> <p>1) Head-to-toe skin assessments were performed on all residents from 12/05/12 through 12/06/12 by licensed nurses to identify any others with indication of any change of condition/puffiness, swelling or redness. Any notable findings were communicated to the attending Physician and responsible party. Notable findings included, but were not limited to, Pressure Ulcers, Arterial Ulcers, Diabetic Neuropathic Ulcers, Venous Insufficiency Ulcers, Surgical Wounds, Skin Tears, Lacerations, Abrasions, Bruises, Burns, Rashes, or a Lesion associated with bleeding, itching, burning, puffiness or swelling, discoloration and/or raised skin areas. The findings were documented by the</p>	F 520			

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F 520	<p>Continued From page 96</p> <p>licensed nurse, and communicated to the Physician and family for further follow-up. The licensed nurse was responsible to document findings in the residents' medical record and the 24 hour report.</p> <p>2) On 12/05/12 and 12/06/12 facility licensed nurses conducted an audit that reviewed all current residents' progress notes and the 24 hour reports for the previous thirty (30) days (11/05/12 to current) to validate changes in resident condition were identified and addressed with the Physician and responsible party notification. This audit also included validating any changes in resident condition including updating the care plan.</p> <p>3) The Administrator (Executive Director) communicated the change in the process for Physician notification by the facility to Hospice on 11/30/12 and again on 12/03/12.</p> <p>4) Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour sift reports would be audited daily starting on 12/06/12 and ongoing by the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), or Quality Assurance (QA) Registered Nurse (RN), Monday through Friday; and by the Weekend Supervisor RN on Saturdays and Sundays for any residents with a change in condition to validate appropriate identification of changes in resident condition, notification of the Physician and responsible party, and care plan revision.</p> <p>5) Shift to shift report was observed daily on each unit beginning 12/10/12 and ongoing by the DNS,</p>	F 520			

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F 520	<p>Continued From page 97</p> <p>ADNS, QA Nurse, Unit Managers (UM), three (3) to eleven (11) Supervisor, Weekend Supervisor, RN Case Manager, District Clinical RN Consultant to validate proper use of the 24 hour report and follow-up to resident change in condition.</p> <p>6) The Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents was placed on the Treatment Administration Record (TAR) on all units 12/06/12 for quick reference for the nurses.</p> <p>7) On 12/04/12 the Staff Development Coordinator (SDC) initiated education with all facility licensed nursing staff related to change in condition of resident status. Inservice dates were 12/04/12, 12/05/12, 12/06/12 and ongoing until all facility clinical staff had received the education. Education was provided by the SDC, ADNS', three (3) to eleven (11) RN Supervisor, Weekend RN, DNS, or QA RN. No nursing staff would be allowed to work until they had received the education. The inservices included: Situation Background Assessment Recommendation/Request (SBAR) form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.</p> <p>8) A Performance Improvement Committee (PIC) meeting was held on 12/05/12 and again on 12/06/12. The Medical Director was notified of</p>	F 520			

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F 520	<p>Continued From page 98</p> <p>the Immediate Jeopardy via telephone and approved the plan developed by the PIC on 12/05/12. The PIC reviewed and approved the Allegation of Compliance (AOC). The PIC was to ensure validation of the AOC by: beginning 12/06/12, initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms, and shift to shift observations were being reviewed by the DNS, ADNS', QA RN, and/or Weekend Supervisor RN on Saturday and Sunday to identify issues, trends or patterns and take corrective action as necessary. The QA RN would be responsible to report trends from the audits to the weekly PIC committee for review and further recommendations. The PIC would create corrective action plans for any areas of concern identified on the audits. The PIC committee would meet weekly or more often as necessary until the facility had removed the Immediate Jeopardy. Once the Immediate Jeopardy was removed the facility would return to routine monthly PIC committee meetings.</p> <p>9) The District and/or Regional team would provide RN clinical oversight a minimum of three (3) days per week beginning the week of 12/02/12.</p> <p>10) The facility contracted an outside clinical consulting group on 11/20/12 to conduct onsite facility clinical oversight two (2) days per week beginning 12/02/12.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>Review of the skin assessment forms revealed all</p>	F 520			

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F 520	<p>Continued From page 99</p> <p>facility residents had skin assessments performed from 12/05/12 through 12/06/12 by licensed nurses, except three (3) who refused and one (1) that was end of life. Audit review revealed newly identified areas were reported to the physician and responsible party.</p> <p>Record review revealed the facility performed the audits as identified on the facility's AOC: An audit of resident progress notes and the 24 hour reports for the last 30 days was performed on 12/05/12 - 12/06/12. Daily audits of Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports started on 12/06/12. Problems identified were given to the Unit Managers for follow-up. The Shift to Shift audits were initiated by the facility on 12/10/12.</p> <p>Observation of the Treatment Administration Record (TAR) on each unit revealed they had Guidelines for Physician Notification of Change of Condition/Clinical Problems in the front.</p> <p>Interview, on 12/13/12 at 11:05 AM, with the Staff Development Coordinator (SDC) revealed she had completed education with facility staff related to the SBAR form, 24 hour report form, alert charting system, notification of the Physician and responsible party, assessing for a possible hip fracture, State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms, Licensed Nurse notification to Hospice for recommendations for a resident with a change in condition, then notify Physician of the change in condition and notify family.</p> <p>Interview, on 12/13/12 at 11:00 AM, with the</p>	F 520			

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F 520	<p>Continued From page 100</p> <p>Executive Director (ED), Vice President of Clinical Operations, Director of District Operations, Director of Nursing Services (DNS), Quality Assurance (QA) RN, and contracted Nurse Consultant revealed the District and/or Regional team would provide RN clinical oversight a minimum of three (3) days per week beginning the week of 12/02/12. In addition, the facility had contracted with an outside clinical consulting group on to conduct onsite facility clinical oversight two (2) days per week.</p> <p>Interviews with licensed nursing staff on 12/12/12 at 11:50 AM with Licensed Practical Nurse (LPN) #40, at 3:00 PM with Registered Nurse (RN) #11, at 3:15 PM with LPN #13; on 12/14/12 (7:00 AM to 3:00 PM shift) at 9:50 AM with LPN #3, at 2:00 PM with LPN #9, at 2:17 PM with LPN #16, at 2:45 PM with LPN #32, at 2:53 PM with LPN #15; on 12/14/12 (3:00 PM to 11:00 PM shift) at 5:35 PM with LPN #2, at 6:00 PM with LPN #31; and, on 12/14/12 (11:00 PM to 7:00 AM shift) at 3:42 PM with LPN #19 and at 4:32 PM with LPN #38 revealed they were all aware the "Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents" was on the Treatment Administration Record (TAR); they had received education on the Situation Background Assessment Recommendation/Request (SBAR) form; the 24 hour report form; the alert charting system; notification of the Physician and responsible party; assessing residents for a possible hip fracture; the State Registered Nursing Staff (SRNA) utilizing the Stop and Watch forms; and after notification to Hospice for recommendations for a resident with a change in condition, that they were to then notify the Physician of the change in</p>	F 520			

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F 520	<p>Continued From page 101</p> <p>condition and obtain orders, then notify the family. All licensed nurses interviewed confirmed that the shift to shift reports were being audited by Unit Managers, Assistant Director of Nursing Services (ADNS), 3:00 PM to 11:00 PM Supervisor, Quality Assurance Registered Nurse, and Weekend Supervisor.</p> <p>Interview, on 12/12/12 at 10:05 AM with State Registered Nursing Assistants (SRNAs) #8 and #9; on 12/14/12 at 9:15 AM with SRNA #37, at 9:15 AM with SRNA #38, at 2:33 PM with SRNA #27, at 3:00 PM with SRNA #32, at 3:40 PM with SRNA #39, at 4:00 PM with SRNA #13, at 4:19 PM with SRNA #34, at 4:28 PM with SRNA #35, at 5:15 PM with SRNAs #33 and #36 revealed they had all received education on the Stop and Watch form for communicating changes in residents' condition to the nurses. Interview, on 12/14/12 at 9:25 AM with LPN #39 and at 9:30 AM with LPN #16 revealed the SRNAs had received training on the Stop and Watch form.</p> <p>Interview, on 12/11/12 at 12:20 PM, with the Director of Nursing Services (DNS) revealed education had been performed with facility staff in regards to the "skin sheet", Stop and Watch form, 24 hour report form, and proper notification of the Physician and family. She stated nurses had been re-educated to confer with Hospice, however they were to notify the Physician and responsible party. In an additional interview, on 12/14/12 at 5:00 PM, with the DNS revealed in the facility's daily clinical review they were monitoring: the notification of change to the Physician and family, care plan updates, 24 hour report forms, alert charting forms, condition change forms, and Stop and Watch forms. She</p>	F 520			

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F 520	<p>Continued From page 102</p> <p>stated any concerns are followed up on by the Unit Managers (UM). The DNS stated she ensures the UMs complete the follow up via another meeting at the end of the day. According to the DNS, shift reports were being audited every day. She stated the audits were to ensure nurses were utilizing the 24 hour report form, alert charting, and any Stop and Watch forms to ensure the following shift was updated on residents' condition changes.</p> <p>Interview, on 12/14/12 at 11:40 AM, with RN #10/Assistant Director of Nursing Services (ADNS) for A and B units, revealed she audited progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days, and also ensured the care plan was updated. In an additional interview with RN #10/ADNS at 5:20 PM revealed she had monitored the shift to shift reports to ensure nurses were utilizing the 24 hour report form, the alert charting form, and any Stop and Watch forms to ensure the oncoming shift was aware of any changes in residents' condition.</p> <p>Interview, on 12/14/12 at 2:00 PM, with RN #2/ADNS (for C and D units) revealed he had performed audits of progress notes, SBAR forms, Physician orders, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports for the past thirty (30) days.</p> <p>Interview, on 12/14/12 at 6:15 PM with the Weekend Supervisor RN revealed he had audited shift to shift reports to ensure the 24 hour report form, the alert charting and any Stop and Watch forms were being utilized to pass on residents'</p>	F 520			

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F 520	<p>Continued From page 103</p> <p>condition changes to the oncoming shift. He stated he had performed audits of the Physician orders, SBAR forms, condition change forms, alert charting lists, stop and watch forms, and 24 hour shift reports.</p> <p>Interview, on 12/14/12 at 6:10 PM, with the Medical Director revealed she had been notified of the Immediate Jeopardy by telephone and had approved the Allegation of Compliance (AOC) after discussion with the facility. She stated the Performance Improvement Committee (PIC) had been meeting weekly since the Immediate Jeopardy was identified and she was involved with these meetings.</p> <p>Interview, on 12/14/12 at 7:15 PM, with the ED and Quality Assurance (QA) RN revealed the Executive Director communicated the change in the process for Physician notification by the facility to Hospice. She stated Hospice had been educated that the facility's nurses would contact the Physician. The QA RN verified that audits were being performed as per the AOC, such as shift to shift report audits to ensure the 24 hour report form and alert charting information was being utilized. The QA RN indicated if audits were performed at shift change then the 24 hour report, alert charting, SBAR forms, and Stop and Watch forms were being audited to ensure a change in a resident's condition is being passed along. According to the QA RN, the results of all the audits on the 24 hour report form, SBAR form, alert charting form, condition change form, care plan updates, Physician orders, Physician and family notification, and Stop and Watch forms were taken to the morning clinical meeting and discussed. The QA RN stated if a problem was</p>	F 520			

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F 520	<p>Continued From page 104</p> <p>identified then staff were educated by the person doing the audit. The QA RN stated he reported the results of the audits and any trends to the weekly PIC meeting. The ED stated education was performed as per the AOC. She stated through the use of the new three (3) part SBAR form and Stop and Watch form that communication was now "shored" up. She stated staff had been educated to ensure a Stop and Watch form was filled out with any change in a resident's condition.</p> <p>An additional interview, on 12/14/12 at 8:00 PM, with the ED revealed the PIC had been meeting weekly. According to the ED, the PIC was performing what was indicated in the AOC (i.e. -validating the AOC by: reviewing initial and daily audits of the Physician orders, condition change forms, alert charting lists, Stop and Watch forms; and shift to shift observations were being reviewed to identify issues, trends or patterns and to take the corrective action as necessary). Corrective action plans for any areas of concern identified on the audits would be implemented.</p>	F 520			