STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185015**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/25/2014**
NAME OF PROVIDER OF SUPPLIER **NHC HEALTHCARE, MADISONVILLE**		STREET ADDRESS, CITY, STATE, ZIP **419 NORTH SEMINARY ST** **MADISONVILLE, KY 42431**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0157

Level of harm - Immediate jeopardy

Residents Affected - Few

Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, record review, review of the facility's policies and procedures, and review of a Hospital emergency room (ER) Note, it was determined the facility failed to immediately consult with the physician for two (2) of nine (9) sampled residents (Resident #1 and Resident #2). On [DATE] at approximately 1:50 PM, Resident #1 was found to be unresponsive and cyanotic (low oxygen causing bluish discoloration of the skin and a late sign of low oxygen levels in the blood) by the Assistant Director of Nursing (ADON) and Floor Nurse. The resident's oxygen saturation was sixty-nine percent (69%, normal ,[DATE]), blood pressure was ,[DATE] mm/Hg (millimeters of mercury), (normal ,[DATE]) and heart rate was 136 beats per minute (bpm) (normal ,[DATE]). The facility failed to call the physician immediately per the facility's policy and procedure. At 2:25 PM, approximately thirty-five (35) minutes later, the facility sent the physician a text message. A physician's orders [REDACTED]. The resident was noted again, at 5:30 PM, to have oxygen saturations of seventy-four percent (74%), labored respirations, and his/her skin was cyanotic. The physician was phoned and a new order was received to send Resident #1 to the emergency room . Resident #1 was admitted to the Critical Care Unit with the [DIAGNOSES REDACTED]. Resident #2 was re-admitted to the facility on [DATE] from a psychiatric hospitalization with new orders for [MEDICATION NAME] (antipsychotic) five (5) milligrams (mg) twice a day. On [DATE], the Consultant Pharmacist performed the monthly medication regimen review and recommended a trial dose reduction of the antipsychotic medication, [MEDICATION NAME], from five (5) mg to two and one half (2.5 mg), two (2) times daily. However, the physician was not made aware of the Pharmacy's Consultant's recommendation. Resident #2 had a fall on [DATE] at approximately 4:00 PM, which resulted in a non-displaced fracture of his/her left clavicle (collarbone). Resident #2 was noted to have a shuffling gait at the time of this fall (a side effect of the [MEDICATION NAME]). The physician was notified of the shuffling gait, and he ordered [MEDICATION NAME]
to help reduce the side effects of the [MEDICATION NAME]. However, the facility failed to make the physician aware of the Consultant's recommendation to do a drug reduction for the [MEDICATION NAME]. Resident #2 had a second fall three (3) days later on [DATE], resulting in three (3) additional fractures of his/her arm (humerus, radius, and ulna). The physician was still not made aware of the Consultant Pharmacy Recommendation to consider a trial dose reduction. There was no documented evidence the physician was made aware of the recommendation until [DATE], at that time, a physician's orders [REDACTED]. The facility's failure to notify and consult with the physician immediately when the resident had a significant change in condition has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE]. The findings include: 1. Review of the facility's policy and procedure titled, Care of Critically Ill Patient/Significant Change in Medical Condition, not dated, revealed when a significant change in medical condition has occurred or the resident is assessed to be critically ill, the attending physician will be notified immediately. Review of the facility's policy and procedure titled, When to Call the Physician Immediately, not dated, revealed that acute changes in vital signs included an increase or decrease in heart rate, respirations, blood pressure, labored breathing, a drop in oxygen saturations, or any other significant changes in the resident's status. Review of the facility's policy and procedure titled, Change in Patient Status, last revised [DATE], revealed in an emergency situation the charge nurse will render appropriate care to the resident, notify the physician, and transfer the patient as appropriate. In addition, the policy stated in the event of an acute change in medical condition and the attending physician was unavailable the nursing partner would take steps necessary to assure appropriate medical intervention. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of a Significant Change Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. Review of a Nurse's Note, dated [DATE] at 1:00 PM, revealed Resident #1 was found to have removed his/her oxygen and further review revealed Resident #1 was educated to leave nasal canula in place. Review of a Nurse's Note, dated [DATE] at 4:00 AM, revealed the resident keeps taking oxygen off. However there was no documented evidence this was addressed in Resident #1's care plan and no documented evidence the facility had made the physician aware. Interview with Certified Nursing Assistant (CNA) #1, on [DATE] at 12:45 PM, revealed Resident #1 had behaviors of taking his/her oxygen off. CNA #1 stated Resident #1 would do this to go to the hospital. Interview with Licensed Practical Nurse (LPN) #2, on [DATE] at 3:04 PM, revealed Resident #1 was non compliant with care at times. She further stated Resident #1 takes the oxygen off at times and we just remind him/her to put it back on. Interview with Registered Nurse (RN) #1, on [DATE] at 8:55 AM, revealed Resident #1 did have a history of taking oxygen off but did not know why he/she did this. Interview with the Resident #1's Physician, on [DATE] at 8:30 AM, revealed that he was not aware of Resident #1 constantly removing his/her oxygen. Review of a Nurse's Note, dated [DATE] at 1:50 PM, revealed Resident #1 was found in his/her bed to be cyanotic and unresponsive. The resident's oxygen saturation was noted to be sixty-nine percent (69%), (normal ,[DATE]), blood pressure was ,[DATE] mm/Hg, (normal ,[DATE]) and heart rate was 136 bpm (normal ,[DATE]). There was no documented evidence the physician was called immediately to notify her of the resident's significant change in condition related to the acute change in vital signs as indicated by an increase or decrease in heart rate, respirations, blood pressure, labored breathing, a drop in oxygen saturations, or any other significant changes in the patient's status as per the facility's policy and procedure. Review of a Nurse's Note, dated [DATE] at 1:55 PM, revealed the resident's oxygen saturation increased to eighty-five percent (85%) on oxygen at four (4) liters per minute and his/her blood pressure was noted to be ,[DATE] mm/Hg. Review of a Nurse's Note, dated [DATE] at 2:25 PM, revealed the oxygen saturation was noted to be eighty-eight (88%) and the physician was sent a text message; however, there was still no documented evidence the physician was called per the facility's policy and procedure due to the low blood pressure and oxygen saturation rate.
Review of a Nurse's Note, dated [DATE] at 3:45 PM, revealed a new order was received approximately one-hour and thirty minutes after the text message to obtain labs and a chest x-ray. At 5:30 PM, approximately three (3) hours and thirty-five (35) minutes after the resident was first identified with the significant change in condition, Resident #1 was noted to be cyanotic, with labored respirations and an oxygen saturation of seventy-four percent (74%) on oxygen at four (4) liters per nasal cannula. The Physician was notified and Resident #1 was sent to the emergency room (ER). Review of a Hospital ER Note, dated [DATE], revealed Resident #1 was placed on a non-rebreather mask with fifteen (15) liters of oxygen when he/she arrived in the ER. Resident #1 was admitted to the Critical Care Unit with [DIAGNOSES REDACTED]. Review of a Provisional Report of Death revealed Resident #1 expired on [DATE] at the hospital. The Provisional Report of Death did not reveal the resident's [DIAGNOSES REDACTED]. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 2:48 PM, revealed she was making rounds on [DATE] at approximately 1:50 PM, and as she approached Resident #1's room she noted the resident had oxygen tubing coiled up around his/her hand. The ADON stated after she placed the oxygen back on Resident #1, he/she

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 0157

Level of harm - Immediate jeopardy

Residents Affected - Few | (continued... from page 1)
was able to state his/her name, the time, and place. The ADON revealed she administered an as needed (PRN) [MEDICATION NAME] nebulizer treatment between 1:50 PM and 1:55 PM; however, she failed to document this information in the Nurse's Notes or on the Medication Administration Record [REDACTED]. She stated, I gave instructions for Registered Nurse (RN #1) to notify the physician; however, I was not aware RN #1 had sent a text message instead of calling the physician. Interview with Registered Nurse (RN) #1, on [DATE] at 8:33 AM; and, on [DATE] at 8:55 AM, revealed she worked on [DATE] during the day shift and was Resident #1's nurse. RN #1 stated the ADON called her to Resident #1's room and as she entered the room, the ADON was putting oxygen on Resident #1, who was cyanotic and unresponsive. She stated we had to do a sternal rub, pat the resident and work with him/her a little to get him/her to respond. RN #1 stated she later sent the physician a text message to inform him of Resident #1's status. She stated according to her message history on her cell phone, the message was not sent to the physician until 3:15 PM rather than 2:25 PM, as the Nurse's Note had stated. RN #1 stated she did not send Resident #1 out to the hospital because the resident stated he/she did not want to go. She further stated Resident #1 was his/her own guardian. However, she was not sure the resident was capable of making that decision and she did not consider this at that time. In addition, she stated the physician had responded to the text message at 3:45 PM with new orders and when Resident #1's oxygen saturations started coming up (oxygen saturation of 88%), I felt like we could manage (him/her) here. RN #1 stated, When we identify a change in condition, we try to notify the physician as soon as possible, but we take care of the resident first. Interview with Licensed Practical Nurse (LPN) #1, Team Leader on Resident #1's unit, on [DATE] at 9:47 AM, revealed her expectation and the facility's policy was to call the physician when a resident had a change in condition. She further stated the resident comes first; in a crisis situation, I would expect the nurse to send the resident out to the hospital and then notify the MD. Interview with the Director of Nursing (DON), on [DATE] at 3:25 PM, revealed her expectation was for the staff to phone the resident's physician immediately when a significant change had been identified. She stated the nurse should not have sent a text message in that situation. The DON stated she expected the nurse to have sent the resident out to the hospital when she assessed the resident to be cyanotic and unresponsive. The DON stated the facility did not have a policy that addressed what to do if a resident refused to be sent to the hospital. Interview with the Administrator, on [DATE] at 4:04 PM, revealed his expectation in a crisis situation was for the staff to phone the physician and do what they needed to do to rescue the resident, and the next thing would be to transfer the resident out to the hospital. Interview with Resident #1's Physician, on [DATE] at 8:30 AM, revealed the resident had an order for [REDACTED].#1 had a history of [REDACTED]. The Physician revealed when the nurse assessed the resident to be cyanotic, and unresponsive with unstable vital signs, the resident should have immediately been sent to the emergency room (ER) at that time. 2. Record review revealed the facility readmitted Resident #2 on [DATE] with [DIAGNOSES REDACTED]. Review of a Significant Change MDS assessment, dated [DATE], revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of eight (8). Review of a physician's orders [REDACTED]. Review of a Consultant Pharmacy Recommendation, dated [DATE], revealed a recommendation for
the physician to consider a trial dose reduction of [MEDICATION NAME] to assess the lowest effective dose, with a recommendation to decrease the dose from five (5) milligram (mg) to two and a half milligram (2.5 mg) twice a day. Further review revealed no documented evidence the facility notified the physician of the pharmacy's recommendation at that time. Review of a Falls Investigation Summary, dated [DATE], revealed Resident #2 had a fall on [DATE] and at the time of the fall the resident was observed shuffling his/her feet which caused him/her to fall. The physician was notified of the fall and the shuffling gait with orders to administer [MEDICATION NAME] to help reduce the side effect (shuffling gait) of [MEDICATION NAME]. However, there was no documented evidence the physician was made aware of the Consultant's Pharmacy Recommendation to decrease the dosage of [MEDICATION NAME]. Review of a Post Falls Investigation, dated [DATE], revealed the resident had an unwitnessed fall on [DATE] at approximately 3:45 AM, while ambulating in the hall unattended. Resident #2 was assessed immediately after the fall and was noted to have complaints of pain to his/her right arm, rating the pain as a ten (10) out of ten (10) on the pain scale. The resident was transferred to the emergency room . Review of a Hospital emergency room (ER) Note, dated [DATE], revealed [DIAGNOSES REDACTED]. Further review revealed an order was written for an
arm sling and splint and to refer the resident to the Orthopedic Surgeon. Review of a Physician's Note, dated [DATE], revealed Resident #2's physician visited him/her at the facility and noted the resident had two (2) significant recent falls resulting in fractures. The physician assessed the resident to be markedly lethargic and confused and discontinued the [MEDICATION NAME] and the [MEDICATION NAME]. Interview with the Consultant Pharmacist, on [DATE] at 1:04 PM, revealed
[MEDICATION NAME] was an antipsychotic medication and it was not the first choice of medications to use in older adults. She stated the side effects of the [MEDICATION NAME] could include Extrapyramidal Symptoms (EPS) such as shuffling gait, abnormal movements and gait disturbance. She revealed the side effects of [MEDICATION NAME] were generally abrupt in nature but may develop at any time. She stated [MEDICATION NAME] was used to control side effects of the [MEDICATION NAME] but if
EPS side effects developed the appropriate thing to do was ask for a reduction. She stated, If the physician had agreed to the trial dose reduction at the time of the recommendation (recommendation was [DATE] and first fall was [DATE]), it was possible the fall could have been avoided. Interview with Resident #2's Physician, on [DATE] at 9:12 AM, revealed he did not recall being made aware of the pharmacy's recommendation to decrease the [MEDICATION NAME] dosage at the time of Resident # 2's falls. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 2:22 PM, revealed she phoned the physician to inform him of the resident's fall and the shuffling gait; however, she did not make the physician aware of the pharmacy's recommendation. She stated, I reported the shuffling gait, and he ordered [MEDICATION NAME] for the side effects of [MEDICATION NAME]. Interview with the Director of Nursing (DON), on [DATE] at 3:37 PM, revealed the ADON should
have made the physician aware of the pharmacy's recommendations at the time of the first fall. Interview with the Administrator, on [DATE] at 4:14 PM, revealed the physician should have been made aware of the pharmacy recommendation at the time of the first fall. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On [DATE], the facility obtained the vital signs of one hundred percent (100%) of all the residents. This was done by the Registered Nurse (RN), Licensed Practical Nurse (LPN) and the Certified Nursing Assistant (CNA) staff. The vital signs included blood pressure (B/P), respiration rate, pulse, temperature, and oxygen saturations to determine if residents presented with vital signs outside established parameters. (B/P 20 points (mm/Hg) above or below ,[DATE], pulse below 60 or above 100, respirations above 20 breaths per minute or below 12 per minute, and a temperature above 99 degrees Fahrenheit.) 2. On [DATE], one hundred percent (100%) of all residents receiving oxygen, residents with a respiratory diagnosis, and residents with [MEDICAL CONDITION] received respiratory assessments by the DON, RN/LPN team leaders. The respiratory assessments included vital signs, oxygen saturations, lung sounds, and observations for any cough or additional complaints. 3. On [DATE]-[DATE], the Director of Nursing (DON) provided an in-service to one hundred percent (100%) of the facility's RNs, LPNs and CNAs regarding the results of the survey/review findings. The DON provided additional in-services to all licensed nurses on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation, which was also completed on [DATE]. In addition, a Respiratory Therapist provided in-service to all licensed nurses regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse/ oxygen which was completed on [DATE]. 4. On [DATE], the Regional Nurse reviewed the twenty-four (24) hour reports to ensure the physician was notified of all residents with a change of condition from [DATE]-[DATE]. 5. Quality Assurance Monitors began the week of [DATE], which included audits of respiratory status/documentation for all residents with respiratory related [DIAGNOSES REDACTED]. In addition, on [DATE], the facility began mock code situations to evaluate the appropriateness of response and action by facility staff. Additionally, on [DATE]-[DATE], the facility verbally interviewed one hundred percent (100%) of all RN and LPN staff regarding when and how to notify the physician in the event of a medical crisis. An additional five (5) weeks of monitoring was added with five (5) interviews per week for five (5) additional weeks. Additional Quality Assurance Monitors included audits to observe the correct oxygen flow, oxygen signs, clean and dated tubing, oxygen tubing off the floor, oxygen saturation monitoring and care plan accuracy which began, on [DATE], for one hundred percent (100%) of all residents receiving oxygen therapy by the Regional Nurse. The State Survey Agency validated the Corrective Action taken by the facility as follows: 1. Interview with the Director of Nursing (DON), on [DATE] at 2:04 PM, revealed the facility obtained the vital signs of one hundred percent (100%) of all the residents on [DATE]. Review of the facility's Vital Sign Audit tool revealed one hundred percent of all the residents had his/her vital signs assessed on [DATE]. 2. Review of the facility's Respiratory Assessment Audit Tool revealed that each resident with a respiratory [DIAGNOSES REDACTED]. Interview with the RN Team Leader (RN #5), on [DATE] at 9:46 AM, the LPN Team Leader (LPN
#10), on [DATE] at 10:04 AM, and the LPN Team Leader (LPN #1), on [DATE] at 10:22 AM, revealed respiratory assessments were completed on their halls daily. They stated the Nurse's Notes were reviewed for accuracy in documentation and the results |

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) of the respiratory assessment were also documented on the audit tool for Quality Assurance. 3. Review, on [DATE], of the inservice logs, dated [DATE], [DATE], [DATE], [DATE], and [DATE], revealed all staff was inserviced related to emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further review, revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse/oxygen Interviews with CNA #3, CNA #4, and CNA #2, on [DATE] at 9:06 AM, 9:12 AM, and 9:16 AM, respectively, revealed they had received in-servicing regarding the survey results. Interviews, on [DATE], with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM; and, on [DATE] with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM, LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been in-serviced regarding the survey results. In addition, they stated they also received in-services on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further interview revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse/oxygen Interviews with RN #4 on [DATE] at 3:45 PM; and, on [DATE] with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had received inservicing regarding the survey results. In addition, they stated they also received in-services on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further interview revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse/oxygen. 4. Interview with the Regional Nurse Consultant, on [DATE] at 12:24 PM, revealed she reviewed the twenty-four hour (24) reports on [DATE] to ensure all residents who were on the 24 hour report, had the appropriate physician notification. Review of the audit reports for the physician notification revealed residents identified with a change of condition received appropriate physician notification. 5. Review of facility audits, dated [DATE], on all residents with a respiratory [DIAGNOSES REDACTED]. Review of the facility's audit reports, dated [DATE], revealed the facility conducted audits regarding residents who were receiving oxygen to observe for the correct oxygen flow, oxygen door signs, clean and dated tubing, oxygen tubing off the floor, oxygen saturation monitoring and care plan accuracy, beginning on [DATE], for one hundred percent (100%) of all residents receiving oxygen therapy by the Regional Nurse. Interview with the Regional Nurse Consultant, on [DATE] at 12:24 PM, revealed she performed an audit on all residents receiving oxygen to observe for the correct oxygen flow, appropriate placement of oxygen signs, clean and dated oxygen tubing, observed for oxygen tubing off the floor, oxygen saturation monitoring and the care plan was accurate and appropriate for all residents receiving oxygen. Interviews on [DATE], with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM, and interviews on [DATE] with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM , LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the LPNs revealed the Director of Nursing (DON) was conducting random mock code situations to monitor and evaluate the appropriateness of response and action by the facility's licensed staff. Interviews with RN #4 on [DATE] at 3:45 PM, and on [DATE] with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the RN staff revealed the Director of Nursing (DON) was conducting random mock code situations to monitor and evaluate the appropriateness of response and action by the facility licensed staff.
F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy and procedures, and review of the Hospital's History and Physical, it was determined the facility failed to review and revise one (1) of nine (9) sampled residents' (Resident #1) care plan to reflect the resident's significant change in condition and the resident's non-compliance with wearing his/her oxygen. Resident #1 was re-admitted to the facility on [DATE]. The facility assessed Resident #1 as requiring two (2) staff for transfers; however, the facility failed to ensure the care plan reflected the assessment findings. On [DATE], Resident #1 was transferred from the bed to his/her recliner by one (1) staff and became too weak to stand and had to be lowered to the floor. The resident sustained [REDACTED]. In addition, Resident #1 had a physician's orders [REDACTED]. On [DATE] at approximately 1:50 PM, Resident #1 was found in his/her bed by the Assistant Director of Nursing (ADON) with the nasal cannula coiled up around his/her hand. The resident was cyanotic (low oxygen causing bluish discoloration of the skin). The resident's oxygen saturation was sixty-nine percent (69%) and his/her oxygen was not in place. Interviews with the direct care staff revealed the resident had a history of [REDACTED]. The facility's failure to review and revise the care plan has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE]. The findings include: Review of the facility's policy and procedure titled, Documentation Guidelines/Care Plans, dated [DATE], revealed care plan approaches should be specific and individualized to assist the resident to achieve a goal. The approaches are the instructions for providing resident care and ensuring the continuity of care. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of a Significant Change Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed Resident #1 as cognitively intact, with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. Further review revealed the facility assessed Resident #1 to require the extensive assistance of two (2) plus persons physical assistance for bed mobility. Review of Resident #1's Comprehensive Care Plan, dated [DATE], revealed an intervention to transfer with the assistance of one (1) to two (2) staff instead of the assessed need of two (2) staff; and, the resident was at risk for signs and symptoms of cardiac/respiratory distress. Interventions included administer oxygen as ordered, check oxygen saturations as needed, observe for signs and symptoms of [MEDICAL CONDITION] and intervene as needed, and to observe for signs and symptoms of respiratory distress and report. Review of a Hospital Discharge Summary, dated [DATE], revealed Resident #1 was hospitalized from [DATE] through [DATE] related to the [DIAGNOSES REDACTED]. Review of a Re-Admission Nursing Assessment, dated [DATE], revealed the facility assessed Resident #1 as totally dependent on two (2) plus person, physical assistance for transfer. Additionally, Resident #1 was assessed to have severe [MEDICAL CONDITION] to all extremities, and the resident was unable to transfer from the bed to wheelchair to be weighed. However, further review of the Comprehensive Care Plan, dated [DATE], revealed the care plan still reflected the need for one (1) to two (2) staff for transfers. Review of a Post Falls Nursing Assessment, dated [DATE], revealed Resident #1 had to be lowered to the floor by a Certified Nursing Assistant (CNA) while transferring him/her from the bed to a chair on [DATE] at 9:30 AM with no injuries identified at the time. The CNA was transferring the resident without assistance. Review of a Nurse's Note, dated [DATE] at 8:55 PM, revealed the facility assessed the resident to have an oxygen saturation of eighty-four percent (84%) on four (4) liters of oxygen. The physician was notified and the resident was sent to the emergency room (ER) via ambulance. Review of a Hospital History and Physical, dated [DATE], revealed Resident #1 complained of right ankle pain and shortness of breath when he/she arrived at the hospital. An x-ray was conducted which revealed a displaced spiral [MEDICAL CONDITION] fibula. Interview with CNA #1, on [DATE] at 12:45 PM, revealed she had entered Resident #1's room to provide personal care. She stated Resident #1 was in his/her bed and had requested to stand up for a minute because he/she had not been out of bed since he/she had been back from the hospital. CNA #1 stated she assisted Resident #1 to stand at the bedside for approximately three (3) to four (4) minutes, then asked Resident #1 if he/she would like to sit in his/her recliner while she made the bed and the resident agreed. Further interview revealed when the resident went to pivot, his/her knee gave out and she (CNA #1) assisted the resident to the floor as much as she possibly could. She stated Resident #1 landed on his/her knees with his/her feet under him/her. CNA #1 stated she had to get the nurse and two (2) additional aides to assist her to get the resident back to bed. She stated the resident didn't complain of pain, but said she was shaken up. CNA #1 stated, Honestly, I didn't know the resident had been in the hospital and had a decline. She stated she was not normally assigned to Resident #1 and it had been a little while since she had worked with him/her. Interview with Licensed Practical Nurse (LPN) #2, on [DATE] at 1:11 PM, revealed she was the nurse on duty at the time of Resident #1's fall. She stated she was called to the room by one of the CNAs to assist with getting the resident back in bed. The LPN stated it took several people to get the resident back in bed. She stated once Resident #1 was back in bed, she immediately did a head to toe skin assessment including range of motion on all extremities, and a full pain assessment. She revealed the assessment was baseline for the resident with no complaints of pain to the lower extremities. LPN #2 stated she checked on the resident approximately thirty (30) minutes after the fall and then was in and out of the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) resident's room the rest of the day. She stated at approximately 8:45 PM, when she entered the resident's room for the medication pass, the resident was kind of shaky and had decreased alertness. She stated she obtained the resident's oxygen saturations and it was eighty-four percent (84%). She stated the resident did not complain of any pain. LPN #2 stated she phoned the physician and sent the resident to the emergency room (ER) via ambulance. Interview with Registered Nurse (RN) #2, on [DATE] at 3:38 PM, revealed she was the nurse who completed the re-admission assessment for Resident #1. She stated the resident required a lot of care due to the [MEDICAL CONDITIONS] and Chronic [MEDICAL CONDITION] Disease ([MEDICAL CONDITION]). RN #2 revealed Resident #1 had chronic pain and fluid overload. She stated the resident had been able to transfer and ambulate with the assistance of one (1) staff member before the hospitalization . RN #2 stated she thought the CNAs would get two (2) staff if it was needed; therefore, she did not update the Comprehensive Care Plan. Interview with CNA #2, on [DATE] at 1:16 PM, revealed she was the primary CNA for Resident #1 most of the time. She stated the resident had gotten weaker since the most recent hospitalization . She stated, Now I am doing everything for the resident because (he/she) just can't do it. Further interview revealed she was no longer able to get the resident up to use the bedside commode per the care plan. CNA #2 stated, I just put the resident on the bed pan. Additionally, CNA #2 stated the resident used to be able to transfer with the assistance of one (1), but he/she needed two (2) staff now. Further review of the Nurse's Notes revealed on [DATE] at 1:50 PM, Resident #1 was found in his/her bed to be cyanotic and he/she was not wearing his/her oxygen. The resident was assessed to have oxygen saturations of sixty-nine percent (69%). In addition, his/her blood pressure was ,[DATE] mm/Hg (millimeters of mercury) and the heart rate was 136 (normal range ,[DATE]). Oxygen was placed on the resident at that time at four (4) liters per nasal cannula. At 1:55 PM, Resident #1's oxygen saturations increased to eighty-five percent (85%) on four (4) liters per nasal cannula and at 2:25 PM, the resident's oxygen saturation was eighty-eight percent (88%). However, at 5:30 PM, the resident's oxygen saturations was seventy-four percent (74%) on four (4) liters of oxygen. The resident was sent to the emergency room (ER). Review of an ER Note, dated [DATE], revealed Resident #1 was admitted to the Critical Care Unit with [DIAGNOSES REDACTED].#1 expired on [DATE] at the hospital. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 2:48 PM revealed she was making rounds on [DATE] at approximately 1:50 PM, and as she approached Resident #1's room she noted the resident was holding the oxygen tubing coiled up around his/her hand. The ADON stated she called for the floor nurse who was also in the hall. The ADON stated after she placed the oxygen back on Resident #1, he/she was able to state his/her name, time, and place. Interview with Registered Nurse (RN) #1, on [DATE] at 8:33 AM; and, on [DATE] at 8:55 AM, revealed she worked on [DATE] during the day shift and was Resident #1's nurse. RN #1 stated Resident #1 did have behaviors of taking his/her oxygen off. She stated, I don't know why (he/she) does that. Interview with Certified Nursing Assistant (CNA) #1, on [DATE] at 12:45 PM, revealed Resident #1 would hold his/her breath at times to make his/her oxygen saturation go down and would take his/her oxygen off at times. She stated the resident would do this, to go back to the hospital. Interview with Licensed Practical Nurse (LPN) #2, on [DATE] at 3:04 PM, revealed Resident #1 was non-compliant with his/her care at times and would take his/her oxygen off at times. She stated, I have sent (him/her) to the emergency room (ER) two (2) times for this since the first of July. Further review of the Comprehensive Care Plan, dated [DATE], revealed there were no interventions to address Resident #1's removing his/her oxygen and no interventions to address monitoring the resident to ensure the resident's oxygen was in place. Interview with RN #3, MDS Coordinator, on [DATE] at 9:43 AM, revealed when a resident was readmitted to the facility from the hospital, the nurse completing the re-admission assessment would update the care plan based on any necessary changes and if a MDS was done, it would be reviewed at that time. In addition, she stated the care plan was developed based on the resident's current conditions and diagnoses. She revealed the care plan would be updated by the nurse taking care of the resident. Interview with the Director of Nursing (DON), on [DATE] at 3:25 PM, revealed she expected care plans to be updated based on the resident's current assessed needs. In addition, she stated, The expectation was, the care plan should be updated when there had been a change in condition or a status change. Interview with the Physician, on [DATE] at 8:30 AM, revealed Resident #1 was a very non-compliant resident and had multiple comorbid diagnoses. He stated staff had not made him aware the resident had behaviors of taking the oxygen off. He revealed that he attended care plan meetings and the nurses were very good at keeping him informed. He stated when the resident's oxygen saturations would drop we would send him/her out to the hospital. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On [DATE], the RN MDS Coordinator completed a review of all residents at the facility with known [DIAGNOSES REDACTED]. The care plans were reviewed to ensure the care plans appropriately addressed the problems and interventions. Additionally, the RN MDS Coordinator completed an audit on 100% of all residents who had returned to the facility post hospitalization beginning [DATE] to ensure appropriate care needs were reflected in the care plan accurately. 2. On [DATE], the Director of Nursing, the RN MDS Coordinator, and the RN/LPN Team Leaders conducted a review of 100% of all care plans with 100% of all physicians orders, nursing interventions, fall interventions, treatment orders, code status, therapy orders, diet orders, adaptive equipment, and labs orders were accurate and appropriately addressed in the care plan. 3. The Director of Nursing conducted inservice training to all licensed staff regarding updating care plan problems based on resident condition changes, updating care plan interventions as new orders/changes occur, updating care plans upon return from the hospital and updating CNA care plans with any changes on the medical record care plan. All RNs and LPNs were inserviced which was completed on [DATE]. 4. 100% of all CNAs were inserviced by the DON and RN/LPN Team Leaders beginning on [DATE] related to care plan location and CNA responsibility to review information for updates on the care plan. The State Survey Agency validated the Corrective Action taken by the facility as follows: 1. Review of the facility's audit of all residents with known [DIAGNOSES REDACTED]. Additionally, review of the audit dated [DATE], revealed 100% of all residents who returned to the facility post hospitalization had care plans reviewed to ensure appropriate care plan needs were accurate. Interview with the RN MDS Coordinator, RN #3 on [DATE] at 10:56 AM, revealed she reviewed the care plans of all residents with the known [DIAGNOSES REDACTED]. In addition, she stated she reviewed all residents readmitted to the facility post hospitalized from [DATE] to [DATE] to ensure accurate and appropriate care plans. 2. Review of a facility's audit dated [DATE], revealed all care plans were reviewed and updated for 100% of all residents to include physician orders, nursing interventions, fall interventions, treatment orders, code status, therapy orders, diet orders, adaptive equipment and lab orders to ensure appropriateness and accuracy. Review of Resident #10's, Resident #11's, Resident #12's, and Resident #13's record revealed the care plans were updated with no concerns noted related to care plans. Interview with the RN Team Leader, RN #5, on [DATE] at 9:46 AM, revealed she completed the care plan audit on [DATE]. She stated all physician orders [REDACTED]. Interview with the LPN/ Team Leader, LPN #1, on [DATE] at 10:22 AM, and LPN #10 on [DATE] at 10:04 AM, revealed all physician orders [REDACTED]. Interview with the RN MDS Coordinator, RN #3, on [DATE] at 10:56 AM, revealed all physician orders [REDACTED]. Interview with the Director of Nursing, on [DATE] at 2:04 PM, revealed she along with the MDS Coordinator and the RN/LPN Team Leaders reviewed 100% of all care plans to ensure accuracy 3. Review of a facility inservice log, dated [DATE] and [DATE], revealed all staff was inserviced regarding updating care plan problems based on resident condition changes, updating care plan interventions as new orders/changes occur, updating care plans upon return from the hospital and updating CNA care plans with any changes on the medical record care plan. Interviews on [DATE], with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM, and interviews on [DATE] with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM, LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been inserviced regarding updating care plan problems based on resident condition changes, updating care plan interventions as new orders/changes occurred, updating care plans upon return from the hospital and updating CNA care plans with any changes on the medical record care plan. Interviews with RN #4 on [DATE] at 3:45 PM; and, on [DATE] with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the RN staff revealed the Director of Nursing was conducting random mock code situations to monitor and evaluate the appropriateness of response and action by the facility licensed staff. 4. Review of a facility inservice log revealed 100% of all CNAs were inserviced by the DON and RN/LPN Team Leaders beginning on [DATE] through [DATE] related to care plan location and CNA responsibility to review information for updates on the care plan. Interviews with CNA #3, CNA #4, and CNA #2, on [DATE] at 9:06 AM, 9:12 AM, and 9:16 AM, respectively, revealed they had been inserviced related to care plan location and CNA responsibility to review information for updates on the care plan.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185015**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/25/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, MADISONVILLE	**419 NORTH SEMINARY ST MADISONVILLE, KY 42431**

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Based on interview, record review, review of the facility's policy and procedure, review of the Hospital emergency room Note, and review of a Provisional Report of Death, it was determined the facility failed to ensure each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the plan of care for one (1) of nine (9) sampled residents (Resident #1). The facility failed to provide ongoing assessments and monitoring for Resident #1 when a significant change in condition was identified. On 07/25/14, at approximately 1:50 PM, Resident #1 was found in his/her room by facility staff unresponsive and cyanotic (low oxygen causing bluish discoloration of the skin). The resident's oxygen saturation was sixty-nine percent (69%) (normal 90-100) on room air, blood pressure was 79/45 (normal 118/68), and heart rate was 136 (normal 60-100) beats per minute (bpm). There was no documented evidence the physician was called to notify her of the resident's significant change in condition; however, at 2:25 PM, thirty-five (35) minutes later, a text message was sent to the physician. At 3:45 PM, a physician's orders [REDACTED]. At 5:30 PM, approximately three (3) hours and ten (10) minutes after the resident's significant change in condition, Resident #1 was noted to be cyanotic, with labored respiration and an oxygen saturation of seventy-four percent (74%). The Physician was notified and a new order was received to send Resident #1 to the emergency room (ER). The resident was transferred to the hospital where he/she was admitted to the Critical Care Unit with the [DIAGNOSES REDACTED]. (Refer to F-157) The facility's failure to ensure each resident received necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the plan of care has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/07/14 and determined to exist on 07/25/14. The findings include: Review of the facility's policy and procedures titled, Care of Critically Ill Patient/Significant Change in Medical Condition, not dated, revealed that when a significant change in medical condition has occurred or the resident is assessed to be critically ill, the attending physician will be notified immediately. Review of the policy titled, When to Call the Physician Immediately, not dated, revealed acute changes in vital signs includes an increase or decrease in heart rate, respirations, blood pressure, labored breathing, a drop in oxygen saturations, or any other significant changes in the resident's status. Review of the facility's policy and procedure titled, Change in Patient Status, revised 03/06/13, revealed in an emergency situation the charge nurse will render appropriate care to the resident, notify the physician, and transfer the patient as appropriate. In addition, the policy stated in the event of an acute change in medical condition and the attending physician was unavailable the nursing partner will take steps necessary to assure appropriate medical intervention. Record review revealed the facility admitted Resident #1 on 10/24/13 with [DIAGNOSES REDACTED]. Review of a Significant Change Minimum Data Set (MDS) assessment, dated 05/08/14 revealed the facility had assessed Resident #1 as cognitively intact with a Brief Interview Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. Review of the Comprehensive Care Plan, dated 05/20/14, revealed Resident #1 was at risk for signs and symptoms of cardiac/respiratory distress with interventions that included administer oxygen as ordered, check oxygen saturations as needed, observe for signs and symptoms of [MEDICAL CONDITION] and intervene as needed and observe for signs and symptoms of respiratory distress and report. Review of the physician's orders [REDACTED]. Review of a Hospital Discharge Summary, dated 07/19/14, revealed Resident #1 was hosptalized on [DATE] through 07/19/14 with Acute onset Chronic [MEDICAL CONDITION]. The facility readmitted Resident #1 on 07/19/14. Review of a Nurse's Note, dated 07/25/14 at 1:50 PM, revealed Resident #1 was found in his/her bed unresponsive and cyanotic with an oxygen saturation of sixty-nine percent (69%) on room air, blood pressure was 79/45 and heart rate was 136 bpm. Oxygen was placed on the resident at four (4) liters per nasal cannula. There was no documented evidence the physician was called and notified of the resident's significant change in condition per the facility's policy and procedures. Further review of the 07/25/14 Nurse's Notes revealed the resident's oxygen saturation was eighty-eight percent (88%) on four (4) liters of oxygen at 2:25 PM and a text message was sent to the physician. At 3:45 PM, new orders were received for labs and a chest x ray. Review of a Nurse's Note at 5:30 PM, revealed Resident #1 was noted to have an oxygen saturation of 74%, labored respirations, and the resident's skin was again noted to be cyanotic. The physician was notified at that time and an order was received to send Resident #1 to the emergency room (ER). However, there was no documented evidence the facility assessed the resident from 2:25 PM to 5:30 PM. Review of an emergency room (ER) Note, dated 07/25/14, revealed Resident #1 was noted to have an altered mental status and was in moderate distress. The resident was placed on a non-rebreather mask with fifteen (15) liters of oxygen. The resident was admitted to the Critical Care Unit with [DIAGNOSES REDACTED]. Interview with the Assistant Director of Nursing (ADON), on 08/06/14 at 2:48 PM, revealed she was making routine rounds and as she approached Resident #1's room she noted that the resident had the oxygen tubing coiled up around his/her hand. She stated she saw the resident's nurse, who was also in the hallway, and summoned her to Resident #1's room. Further interview with the ADON revealed after she placed the oxygen back on Resident #1, the resident was able to state his/her name, time, and place. The ADON revealed she administered an as needed (PRN) [MEDICATION NAME] nebulizer treatment between the time of 1:50 PM and 1:55 PM but did not document this in the Nurse's Notes or on the Medication Administration Record [REDACTED]. The ADON stated Resident #1 did not want to be sent out to the hospital. Further interview revealed the ADON stated the resident was monitored as she checked on the resident throughout the day, and the Certified Nursing Assistants perform every two (2) hour checks, so someone was in and out of the room all the time. Interview with Registered Nurse (RN) #1, on 07/31/14 at 8:33 AM; and, on 08/06/14 at 8:55 AM revealed she had worked on 07/25/14 during the day shift and was the nurse for Resident #1. RN #1 stated she was summoned to Resident #1's room by the Assistant Director of Nursing (ADON) who was standing at the resident's doorway. RN #1 revealed she entered the room, and the ADON was putting oxygen on Resident #1. RN #1 stated Resident #1 was cyanotic and unresponsive and we had to do a sternal rub, pat (him/her) and work with (him/her) a little to get (him/her) to respond. Just a few minutes after the ADON put the O2 on the resident, (his/her) O2 sats came up to 85%. Further interview with RN #1 revealed she did not send Resident #1 out to the hospital because the resident stated he/she did not want to go. She further stated Resident #1 was his/her own guardian; however, she was not sure the resident was capable of making that decision, but she did not consider that at the time. Further interview revealed, she continued to monitor Resident #1 throughout the day, she stated, I was going back in (his/her) room every little bit to make sure that (his/her) oxygen was on because (he/she) would take it off. She further revealed, she continued to observe Resident #1's color, and the resident's oxygen saturation. She stated, I was concerned about (his/her) oxygen saturations being a little low; however, I felt like Resident #1 was making an improvement. In addition, RN #1 revealed she did not document the assessments in the resident's medical record; however, no explanation was provided as to why this was not completed. Interview with Resident #1's Physician, on 08/01/14 at 8:30 AM, revealed the resident was legally competent; however, was very non-compliant and had multiple comorbid diagnoses. He stated the physician orders [REDACTED]. The Physician revealed Resident #1 had a history of [REDACTED]. The Physician stated when the nurse assessed the resident to be cyanotic, unresponsive with unstable vitals, the resident should have been sent out immediately to the ER at that time. Interview with the Director of Nursing, (DON) on 08/07/14 at 3:25 PM, revealed that based on the documentation the resident was not capable of determining if he/she was going to the hospital. Further interview revealed the DON stated, I do expect the staff should have sent the resident out to the hospital, absolutely. She stated the facility did not have a policy to address what to do when a resident refused to be sent to the hospital. Additionally, she stated the nurse should have not sent a text message to the physician and should have phoned him immediately. Interview with the Administrator, on 08/07/14 at 4:04 PM, revealed he expected the staff to phone the physician in a crisis situation, rescue the resident, and transfer the resident out to the hospital. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 08/07/14, the facility obtained the vital signs of one hundred percent (100%) of all the residents. This was done by the Registered Nurse (RN), Licensed Practical Nurse (LPN) and the Certified Nursing Assistant (CNA) staff. The vital signs included blood pressure (B/P), respiration rate, pulse, temperature, and oxygen saturations to determine if residents presented with vital signs outside established parameters. (B/P 20 points (mm/Hg) above or below 120/80, pulse below 60 or above 100, respirations above 20 breaths per minute or below 12 per minute, and a temperature above 99 degrees Fahrenheit. 2. On 08/09/14, one hundred percent (100%) of all residents receiving oxygen, residents with a respiratory diagnosis, and residents with [MEDICAL CONDITION] received respiratory assessments by the DON, RN/LPN team leaders. The respiratory assessments included vital signs, oxygen saturations, lung sounds, and observations for any cough or additional complaints. 3. On 08/08/14-08/13/14, the Director of Nursing (DON) provided an in-service to one hundred percent (100%) of the facility's RNs, LPNs and CNAs regarding the results of the survey/review findings. The DON provided additional in-services to all licensed nurses on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation, which was also completed on 08/13/14. In addition, a Respiratory Therapist provided in-service to all licensed nurses regarding signs of

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NAME OF PROVIDER OF SUPPLIER **NHC HEALTHCARE, MADISONVILLE**		STREET ADDRESS, CITY, STATE, ZIP **419 NORTH SEMINARY ST MADISONVILLE, KY 42431**	

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse oxygen which was completed on 08/13/14. 4. On 08/12/14, the Regional Nurse reviewed the twenty-four (24) hour reports to ensure the physician was notified of all residents with a change of condition from 08/01/14-08/12/14. 5. Quality Assurance Monitors began the week of 08/10/14, which included audits of respiratory status/documentation for all residents with respiratory related [DIAGNOSES REDACTED]. In addition, on 08/09/14, the facility began mock code situations to evaluate the appropriateness of response and action by facility staff. Additionally, on 08/12/14-08/13/14, the facility verbally interviewed one hundred percent (100%) of all RN and LPN staff regarding when and how to notify the physician in the event of a medical crisis. An additional five (5) weeks of monitoring was added with five (5) interviews per week for five (5) additional weeks. Additional Quality Assurance Monitors included audits to observe the correct oxygen flow, oxygen signs, clean and dated tubing, oxygen tubing off the floor, oxygen saturation monitoring and care plan accuracy which began, on 08/14/14, for one hundred percent (100%) of all residents receiving oxygen therapy by the Regional Nurse. The State Survey Agency validated the Corrective Action taken by the facility as follows: 1. Interview with the Director of Nursing (DON), on 08/20/14 at 2:04 PM, revealed the facility obtained the vital signs of one hundred percent (100%) of all the residents on 08/07/14. Review of the facility's Vital Sign Audit tool revealed one hundred percent of all the residents had his/her vital signs assessed on 08/07/14. 2. Review of the facility's Respiratory Assessment Audit Tool revealed that each resident with a respiratory [DIAGNOSES REDACTED]. Interview with the RN Team Leader (RN #5), on 08/20/14 at 9:46 AM, the LPN Team Leader (LPN #10), on 08/20/14 at 10:04 AM, and the LPN Team Leader (LPN #1), on 08/20/14 at 10:22 AM, revealed respiratory assessments were completed on their halls daily. They stated the Nurse's Notes were reviewed for accuracy in documentation and the results of the respiratory assessment were also documented on the audit tool for Quality Assurance. 3. Review, on 08/19/14, of the inservice logs, dated 08/08/14, 08/09/14, 08/10/14, 08/11/14, and 08/13/14, revealed all staff was inserviced related to emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further review, revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse oxygen Interviews with CNA #3, CNA #4, and CNA #2, on 08/20/14 at 9:06 AM, 9:12 AM, and 9:16 AM, respectively, revealed they had received in-servicing regarding the survey results. Interviews, on 08/19/14, with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM, and on 08/20/14 with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM, LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been in-serviced regarding the survey results. In addition, they stated they also received in-services on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further interview revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse oxygen Interviews with RN #4 on 08/19/14 at 3:45 PM, and on 08/20/14 with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had received inservicing regarding the survey results. In addition, they stated they also received in-services on emergency care of the resident, when to send a resident to the hospital, and respiratory assessment and documentation. Further interview revealed they received an inservice provided by the Respiratory Therapist regarding signs of severe respiratory distress, signs of imminent respiratory distress, and vital sign assessment/pulse oxygen 4. Interview with the Regional Nurse Consultant, on 08/20/14 at 12:24 PM, revealed she reviewed the twenty-four hour (24) reports on 08/12/14 to ensure all residents who were on the 24 hour report, had the appropriate physician notification. Review of the audit reports for the physician notification revealed residents identified with a change of condition received appropriate physician notification. 5. Review of facility audits, dated 08/09/14, on all residents with a respiratory [DIAGNOSES REDACTED]. Review of the facility's audit reports, dated 08/14/14, revealed the facility conducted audits regarding residents who were receiving oxygen to observe for the correct oxygen flow, oxygen door signs, clean and dated tubing, oxygen tubing off the floor, oxygen saturation monitoring and care plan accuracy, beginning on 08/14/14, for one hundred percent (100%) of all residents receiving oxygen therapy by the Regional Nurse. Interview with the Regional Nurse Consultant, on 08/20/14 at 12:24 PM, revealed she performed an audit on all residents receiving oxygen to observe for the correct oxygen flow, appropriate placement of oxygen signs, clean and dated oxygen tubing, observed for oxygen tubing off the floor, oxygen saturation monitoring and the care plan was accurate and appropriate for all residents receiving oxygen. Interviews on 08/19/14, with LPN #3 at 3:57 PM, LPN #4 at 4:10 PM, LPN #5 at 4:23 PM, and interviews on 08/20/14 with LPN #6 at 8:12 AM, LPN #7 at 8:21 AM, LPN #8 at 8:31 AM , LPN #9 at 8:42 AM, and LPN #10 at 10:04 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the LPNs revealed the Director of Nursing(DON) was conducting random mock code situations to monitor and evaluate the appropriateness of response and action by the facility's licensed staff. Interviews with RN #4 on 08/19/14 at 3:45 PM, and on 08/20/14 with RN #5 at 9:46 AM, RN #3 at 10:56 AM, and RN #6 at 11:08 AM, revealed they had been verbally interviewed regarding when and how to notify the physician in the event of a medical crisis. In addition, interview with the RN staff revealed the Director of Nursing (DON) was conducting random mock code situations to monitor and evaluate the appropriateness of response and action by the facility licensed staff.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy and procedure, and review of the Hospital History and Physical, Hospital emergency room Note it was determined the facility failed to provide adequate supervision to prevent accidents for two (2) of nine (9) sampled residents (Resident #1 and Resident #2). Resident #2 was re-admitted to the facility on [DATE] from a psychiatric hospitalization with new orders for an antipsychotic medication, Haldol five (5) milligrams (mg) twice a day. On [DATE], the Consultant Pharmacist, during the monthly medication regimen review recommended a trial dose reduction of Haldol from five (5) mg to two and one half (2.5 mg). On [DATE], Resident #2 had a fall with injury and was noted at the time of the fall, to have a shuffling gait, which was a side effect of the Haldol. Resident #2 was diagnosed with [REDACTED]. The physician was notified of the shuffling gait; however, was not notified of the Consultant Pharmacist's recommendation. The physician ordered Cogentin, a medication to help reduce the side effects of the antipsychotic medication, Haldol. Resident #2 had a second fall three (3) days later on [DATE] resulting in three (3) additional fractures (his/her humerus, radius, and ulna). The physician was not made aware of the recommendation until [DATE], after the resident had sustained two (2) falls with injury. On [DATE], the facility assessed Resident #1 as dependent on two (2) staff for transfers; however, review of the care plan revealed an intervention for one (1) to two (2) staff to transfer. On [DATE], Resident #1 was lowered to the floor during a transfer when he/she was being transferred by one (1) Certified Nursing Assistant (CNA). Resident #1 sustained a fracture of the right fibula (leg bone) after the fall. The resident was assessed as having a significant decline in ADLs and expired at the facility on [DATE]. The facility's failure to provide adequate supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE]. The findings include: Review of the facility's policy and procedures titled Accidents and Incident Investigations not dated, revealed that when an accident occurs, the staff are to identify the activity and cause of the fall, perform a review of the resident's medication, update the care plan and ensure all appropriate parties are notified. 1. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of a Significant Change Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed the resident as requiring the extensive physical assistance of two (2) plus persons for transfers. In addition, review of an Admission Nursing Assessment conducted on [DATE], revealed Resident #1 was totally dependent on two (2) plus staff for transfers. However, review of the Comprehensive Care Plan, dated [DATE], revealed an intervention to provide the assistance of one (1) to two (2) staff with transfers. Review of a Post Falls Nursing Assessment, dated [DATE], revealed one CNA was transferring Resident #1 from the bed to the chair on [DATE] at 9:30 AM, when the resident had to be lowered to the floor. There were no injuries identified at the time. However, review of a Hospital History and Physical, dated [DATE], revealed Resident #1 complained of right ankle pain and shortness of breath when he/she arrived at the hospital. An x-ray was conducted which revealed a displaced spiral fracture of the distal fibula. Interview with CNA #2, on [DATE] at 1:16 PM, revealed she was the primary aide for Resident #1 most of the time. She stated the resident had gotten weaker since his/her most recent hospitalization . CNA #2 stated, Now I am doing everything for the resident because he/she just can't do it. She revealed she was no longer able to get the resident

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NAME OF PROVIDER OF SUPPLIER **NHC HEALTHCARE, MADISONVILLE**	STREET ADDRESS, CITY, STATE, ZIP **419 NORTH SEMINARY ST MADISONVILLE, KY 42431**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) up to use the bedside commode per the care plan. She stated, I just put the resident on the bed pan. Interview with Licensed Practical Nurse (LPN) #2, on [DATE] at 1:11 PM, revealed she was the nurse on duty at the time of Resident #1's fall. She stated she was called to the room by a CNA to assist with getting the resident back in bed which required several people to get him/her back in bed. She stated she assessed the resident and did not identify any injuries and the resident had no complaints of pain. LPN #2 stated at approximately 8:45 PM, she went to administer Resident #1's medication and the resident was kind of shaky and had decreased alertness. She stated the resident's oxygen saturation was eighty-four percent (84%) and the resident had no complaints of pain. LPN #2 stated she phoned the physician and sent the resident to the emergency room (ER) via ambulance. Interview with Registered Nurse (RN) #2, on [DATE] at 3:38 PM, revealed she was the nurse who completed the re-admission assessment for Resident #1. She stated the resident required a lot of care due to the Congestive Heart Failure and Chronic Pulmonary Disease. RN #2 stated Resident #1 had chronic pain and fluid overload. RN #2 stated the resident had been able to transfer and ambulate with the assistance of one (1) staff member before his/her hospitalization and she thought the CNAs would get two (2) staff if it was needed, therefore she did not update the Comprehensive Care Plan to ensure adequate supervision was provided. Interview with RN #3, MDS Coordinator, on [DATE] at 9:43 AM, revealed when a resident was readmitted to the facility from the hospital, the nurse completing the re-admission assessment would update the care plan based on any necessary changes and if an MDS was done, it would be reviewed at that time. She stated the care plan should be based on the resident's current conditions and diagnoses 2. Record review revealed the facility readmitted Resident #2 on on [DATE] with [DIAGNOSES REDACTED]. Review of a Significant Change MDS assessment, dated [DATE], revealed the facility assessed the resident to require supervision only with transfers and ambulation. Review of Resident #2's Comprehensive Care Plan, dated [DATE], revealed Resident #2 was at risk for falls related to impaired balance during transitions and walking, and the use of multiple psychoactive medications. Interventions included to observe for unsafe actions such as unassisted transfers and intervene as needed. Review of a Post Falls Nursing Assessment and Falls Investigation Summary, dated [DATE], revealed Resident #2 had a fall on [DATE], and at the time of the fall the resident was observed shuffling his/her feet which caused him/her to fall. The resident was assessed immediately after the fall and it was noted that the resident had complaints of pain, rating the pain as an eight (8) out of ten (10) on the pain rating scale. The resident also had a two (2) centimeter laceration above his/her left eyebrow area with bruising and swelling. The resident's left eye was cleaned with normal saline and the resident was given a cold pack to the left eyebrow area. Review of the Comprehensive Care Plan, updated [DATE], revealed a referral screen for therapy related to shuffling gait and Cogentin, as ordered. Review of a physician's orders [REDACTED]. Review of the Post Falls Investigation, dated [DATE], revealed a physician's orders [REDACTED]. Further review of a Physician's Note, dated [DATE], revealed the resident sustained [REDACTED]. Review of a Post Falls Investigation, dated [DATE], revealed the resident had an unwitnessed fall on [DATE] at approximately 3:45 AM, when he/she was ambulating in the hall unsupervised. Resident #2 was assessed immediately after the fall and noted the resident to have complaints of pain to his/her right arm, rating the pain as a ten (10) out of ten (10) on the pain scale. Review of a Nurse's Note, dated [DATE] at 4:00 AM, revealed Resident #2 continued to complain of pain in his/her arm and stated he/she was unable to move his/her arm. Further review revealed the physician was notified and Resident #2 was sent to the emergency room . Review of a Hospital emergency room Note, dated [DATE], revealed Resident #2 received x-rays of his/her arm and was diagnosed with [REDACTED]. Further review revealed the resident received a splint to his/her right wrist and a sling for his/her right arm and was discharged back to the facility on [DATE]. Review of a Significant Change MDS Assessment, dated [DATE], revealed the facility had assessed Resident #2 as having severe cognitive impairment, and was rarely or never understood and unable to complete the Mental Status Assessment. In addition, the facility had assessed Resident #2 to require extensive, two (2) plus persons physical assist with bed mobility, transfer and ambulation. Review of a Consultant Pharmacy Recommendation, dated [DATE], revealed a recommendation for the physician to consider a trial dose reduction of Haldol (an antipsychotic medication), as there was no documented evidence of the resident exhibiting behaviors for the use of the medication. The Haldol was to be decreased from five (5) to two and a half milligram (2.5 mg) twice a day. Review of a physician's orders [REDACTED]. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 2:22 PM, revealed she phoned the physician to inform him of the resident's fall and noted shuffling gait (side effect of Haldol). The ADON stated she was not sure if the physician was aware of the Pharmacy Consultant's recommendation when she phoned to report the fall related to the shuffling gait. She stated she reported the shuffling gait, and he ordered Cogentin for the side effects of Haldol. Interview with the Director of Nursing (DON), on [DATE] at 3:37 PM, revealed the ADON and the Team Leaders work with the pharmacy recommendations to ensure they were addressed by the physician. She stated ultimately it was the DON's responsibility to make sure the pharmacy recommendations were addressed. She stated she was not sure how this was overlooked. Further interview revealed the physician should have been made aware of the Consultant Pharmacist's recommendations ([DATE]) at the time of the first fall ([DATE]). Further interview revealed Resident #1 did not receive a therapy evaluation at that time and the order was put on hold related to the new [DIAGNOSES REDACTED]. Additionally, the DON stated, The care plan was not updated related to the falls, and it should have been. Interview with the Administrator, on [DATE] at 4:14 PM, revealed the physician should have been made aware of the Pharmacist's recommendations at the time of the first fall. Interview with the Consultant Pharmacist, on [DATE] at 1:04 PM, revealed the side effects of the Haldol could include a shuffling gait, abnormal movements and gait disturbance. Further interview revealed the side effects of Haldol were generally abrupt in nature but could develop at any time. She stated Cogentin was used to control the side effects of the Haldol. Further interview revealed if side effects developed the appropriate thing to do was to ask for a reduction. She stated, If the physician had agreed to the trial dose reduction at the time of recommendation, it is possible the fall could have been avoided. Interview with Resident #2's Physician, on [DATE] at 9:12 AM, revealed he did not know if he was aware Resident #2 had a shuffling gait at the time of his/her fall. Additionally, he stated that he did not recall being made aware of the Consultant Pharmacist's recommendations ([DATE]) at the time of Resident # 2's fall on [DATE]. Additionally, he stated he ordered the medication, Cogentin when he was made aware of the shuffling gait. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On [DATE] through [DATE] the DON and RN/LPN Team Leaders audited the investigations of 100% of eighteen (18) residents that fell from [DATE] through [DATE] to ensure that previous investigation of the falls were appropriate. 2. On [DATE] the DON, RN/LPN Team Leaders and RN MDS Coordinator reviewed 100% of the care plans to ensure current physician orders, treatments, code status, diet orders, fall interventions, nursing tasks, therapy orders, adaptive equipment, and labs were included on the care plan. 3. On [DATE], the DON revised the falls review process which included daily meetings Monday through Friday to review the nursing notes, medications, care plan, staff statements, and details regarding the falls of any resident who had a fall. In addition, the falls team cross checks the pharmacy recommendations within the proceeding thirty (30) days. Additionally, any falls that occur after hours or on the weekend the DON or ADON is notified prior to the end of the shift to ensure appropriate interventions and actions were taken. 4. Beginning on [DATE], the CNAs will be interviewed by the RN/LPN team leaders, twelve (12) per week for five (5) weeks to ensure there understanding of the care plans. 5. All QA monitors will be reported to the QA Committee and will continue as directed by the QA Committee and Regional Nurse. The State Survey Agency validated the Corrective Action taken by the facility as follows: 1. Interview with the DON on [DATE] at 1:06 PM revealed she along with the RN/LPN Team Leaders audited the investigations of 100% of eighteen (18) residents that fell from [DATE] through [DATE] to ensure that previous investigation of the falls were appropriate. Interview with Team Leader (RN #5) on [DATE] at 9:51 AM revealed she audited the investigations of 100% of eighteen (18) residents that fell from [DATE] through [DATE] to ensure that previous investigation of the falls were appropriate. Interview with the Team Leader (LPN #1) on [DATE] at 10:27 AM revealed she audited the investigations of 100% of eighteen (18) residents that fell from [DATE] through [DATE] to ensure that previous investigation of the falls were appropriate. 2. Interview with the DON on [DATE] at 1:06 PM revealed she reviewed 100% of the care plans to ensure current physician orders, treatments, code status, diet orders, fall interventions, nursing tasks, therapy orders, adaptive equipment, and labs were included on the care plan. Interview with Team Leader (RN # 5) on [DATE] at 9:51 AM revealed she audited 100% of the care plans to ensure current physician orders, treatments, code status, diet orders, fall interventions, nursing tasks, therapy orders, adaptive equipment, and labs were included on the care plan. Interview with Team Leader (LPN # 1) on [DATE] at 10:27 AM, revealed she audited 100% of the care plans to ensure current physician orders, treatments, code status, diet orders, fall interventions, nursing tasks, therapy orders, adaptive equipment, and labs were included on the care plan. 3. Interview with the DON on [DATE] at 1:06 PM revealed she revised the falls review process which included daily meetings Monday through Friday to review the nursing notes, medications, care plan, staff statements, and details regarding the falls of any resident who had a fall. In addition, she stated the falls team cross checks the pharmacy recommendations within the

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) proceeding thirty (30) days. Additionally, any falls that occur after hours or on the weekend the DON or ADON is notified prior to the end of the shift to ensure appropriate interventions and actions taken. 4. Interview on [DATE] with CNA #6 at 4:18 PM, CNA #7 at 4:20 PM, CNA #8 at 4:22 PM and CNA #9 at 4:25 PM, revealed they were interviewed by the RN/LPN Team Leaders related to the location and interventions on the residents care plans. 5. Interview with the Activities Director on [DATE] at 12:37 PM revealed she is a member of the QA Committee and has been informed of the progress and results of the audit tool and monitors in place at the facility. Interview with the Licensed Social Worker (LSW) on [DATE] at 12:42 PM revealed she is a member of the QA Committee and has been informed of the progress and results of the audit tools and monitors in place at the facility.
F 0428 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to ensure the pharmacist's recommendation for a gradual dose reduction was reported to the attending physician in order for the reports to be acted upon for one (1) of nine (9) sampled residents (Resident #2). Resident #2 was re-admitted to the facility on [DATE] from a psychiatric hospitalization with a new order for Haldol (antipsychotic) five (5) milligrams (mg) twice a day. On 06/03/14, the Consultant Pharmacist performed the monthly medication regimen review and recommended a trial dose reduction of the Haldol from five (5) mg to two and one half (2.5 mg), two (2) times daily; however, the facility failed to ensure the physician was made aware of the report and that it was acted upon. On 06/12/14 at approximately 4:00 PM, approximately nine (9) days after the recommendation was made, Resident #2 had a fall which resulted in a fracture to his/her left clavicle (collarbone). Resident #2 was noted to have a shuffling gait which was a side effect of the antipsychotic medication. The physician was made aware of the shuffling gait but the facility failed to make the physician aware of the Consultant's recommendation. The physician ordered Cogentin to help reduce the side effects of the Haldol. Resident #2 had a second fall three (3) days later on 06/15/14, which resulted in fractures of the resident's humerus, radius, and ulna (arm); the physician was still not made aware of the Consultant's recommendation to consider a trial dose reduction. The physician was not notified of the pharmacy recommendations until 06/17/14, approximately fourteen (14) days after the recommendation. The physician reduced the Haldol dosage to two (2) milligrams (mg) twice a day. The physician visited the resident on 06/19/14 and discontinued the Haldol and Cogentin due to the resident having the two (2) significant falls and noting the resident was markedly lethargic. The facility's failure to notify the physician of the pharmacy recommendation for the gradual dose reduction of the antipsychotic medication has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/23/14 and was determined to exist on 06/15/14. The findings include: Review of the facility's policy and procedure titled, Consultant Pharmacist Reports, dated 10/2011, revealed the consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendations regarding residents' medication therapy are communicated to those with authority and /or responsibility to implement the recommendations, and respond in an appropriate and timely fashion. Further review revealed the Consultant Pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for the prescriber and/or nursing review. Additionally, review of the policy revealed the comments and recommendations concerning medication therapy were to be communicated in a timely fashion. Review of the facility's policy and procedures titled, Medication Monitoring and Management, dated 10/2011, revealed when a resident's clinical condition had improved or stabilized, the underlying causes of the original target symptoms had resolved, and/or non-pharmacological interventions, including behavioral interventions, had been effective in reducing the symptoms, the resident would be evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication. Record review revealed the facility admitted Resident #2 on 01/28/14; and readmitted him/her on 04/08/14 with [DIAGNOSES REDACTED]. Review of the readmission orders [REDACTED]. Review of Resident #2's Behavior Flow Record, dated 05/2014, revealed Resident #2 was monitored for throwing objects, hitting staff, and paranoid behavior. Staff was to evaluate the effectiveness of the antipsychotic medication Haldol. Further review revealed no behaviors were reported during that time. Review of a Pharmacy Recommendation, dated 06/03/14, revealed a recommendation for the physician to consider a trial dose reduction of Haldol. The Haldol was to be decreased from five (5) to two and a half milligram (2.5 mg) twice a day. Review of a physician's orders [REDACTED]. The Haldol was decreased to two (2) milligrams. Review of a Falls Investigation Summary, dated 06/13/14, revealed Resident #2 had a fall on 06/12/14 and at the time of the fall the resident was observed shuffling his/her feet which caused him/her to fall. The physician was made aware of the shuffling gait and ordered Cogentin to help reduce the side effects of the Haldol. Further review revealed, the resident was assessed immediately after the fall and noted to have complaints of pain, rating the pain as an eight (8) out of ten (10) on the pain rating scale. Further review of the Summary revealed the resident had a two (2) centimeter laceration above his/her left eyebrow area with bruising and swelling. The resident's left eye was cleansed with normal saline and the resident was given a cold pack to apply to his/her left eyebrow area. Review of a physician's orders [REDACTED]. Further Review of the POS [REDACTED]. Review of a Physician's Note, dated 06/19/14, revealed resident sustained [REDACTED]. Review of a Post Falls Investigation, dated 06/17/14, revealed the resident had an unwitnessed fall on 06/15/14 at approximately 3:45 AM, when he/she was ambulating in the hall unsupervised. Resident #2 was assessed immediately after the fall and had complaints of pain to his/her right arm, rating the pain as a ten (10) out of ten (10) on the pain scale. Review of a Nurse's Note, dated 06/15/14 at 4:00 AM, revealed Resident #2 continued to complain of pain in his/her arm and stated he/she was unable to move his/her arm. Further review revealed the physician was notified and Resident #2 was sent to the emergency room . Review of a Hospital emergency room Note, dated 06/15/14, revealed Resident #2 received x-rays of his/her arm and was diagnosed with [REDACTED]. Further review revealed the resident received a splint to his/her right wrist and a sling for his/her right arm and was discharged back to the facility on [DATE]. The physician ordered for the facility to follow up with an Orthopedic Surgeon in three (3) days. Interview with the Consultant Pharmacist, on 08/06/14 at 4:56 PM, revealed she performed medication regimen reviews at least monthly at the facility. She stated after she completed the pharmacy review, she would print the pharmacy recommendations and give them to the DON or the ADON. She stated they were hand delivered or placed in their mailboxes. She revealed she visits the facility monthly and each month she tracks the month before to ensure all recommendations were addressed and received a follow up. She stated if she finds a recommendation that has not been responded to she will reprint and alert the DON/ADON. Interview with the ADON, on 07/30/14 at 2:22 PM; and, on 08/05/14 at 9:00 AM, revealed the Consultant Pharmacist performs medication regimen reviews on each resident at least monthly. The ADON stated, Once the reviews were completed, the Pharmacy Consultant would print the recommendations, and give them to us (DON/ADON) to follow up on. The ADON stated, Once I receive the recommendations, I would phone the physician and make him aware of the recommendations received. The ADON revealed sometimes the physician would give an immediate verbal order and sometimes the physician would wait until he was at the facility to make rounds at least once a week. The ADON stated, I do not know how the recommendation slipped through the cracks. Interview with the DON, on 08/07/14 at 3:37 PM, revealed the ADON and the Team Leaders work with the pharmacy's recommendations to ensure they were addressed by the physicians. She stated ultimately it was the her (DON's) responsibility to make sure the pharmacy recommendations were addressed. She stated she was not sure how this was overlooked. She stated when the Pharmacy Consultant completed the reviews, the Pharmacy Consultant printed the recommendations and gave them to the DON or the ADON for follow-up. Interview with Resident #2's Physician, on 08/01/14 at 9:12 AM, revealed he did not recall being made aware of the Pharmacy Consultant's Recommendation at the time of Resident #2's fall on 06/12/14. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 08/08/14 the Consultant Pharmacist reviewed the medical record of 100% of all patients on antipsychotic medications to assure diagnosis, dosages, duration, required lab work and gradual dose reduction were appropriate. 2. On 08/28/14 the DON and RN/LPN Team Leaders reviewed 100% of the pharmacy recommendations for 07/2014 to ensure they were acted upon within fourteen (14) days of writing, per the policy and procedure. 3. On 08/08/14 the DON met with the Consultant Pharmacist to review the correct practice of pharmacy recommendation review and the DON was trained by the Consultant Pharmacist on the revised practice and the DON trained the RN/LPN Team Leaders. 4. Review of the Consultant Pharmacist recommendations continue to be performed to assure compliance with-in a seven (7) day response guidelines, and the physician response to recommendations. In addition, the pharmacy recommendations will be monitored by the DON for

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F 0428 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) completion weekly until 100 % compliance achieved and Quality Assurance (QA) Committee deems appropriate. 5. The Consultant Pharmacist will continue to conduct monthly medication reviews of all residents on antipsychotic medications and make recommendations as deemed necessary. These reviews will be evaluated for compliance with recommendations by the DON. The medication review will be continued monthly as required by regulation and the audit of compliance with recommendation will continue until the QA Committee deems compliance is achieved and maintained. 6. All QA monitors will be reported to the QA Committee and will continue as directed by the QA Committee and Regional Nurse. The State Survey Agency validated the Corrective Action taken by the facility as follows: 1. Interview with the Consultant Pharmacist on 09/25/14 at 10:07 AM, revealed she reviewed the medical record of 100% of all patients 08/08/14 who were on antipsychotic medications to assure diagnosis, dosages, duration, required lab work and gradual dose reduction were appropriate. Review of the facility's Pharmacy Anti-Psychotic Drug Audit dated 08/2014 and 09/2014 revealed 100% of all residents had a medication regimen review completed by the Consultant Pharmacy. 2. Interview with the DON on 09/25/14 at 1:01 PM revealed she reviewed 100% of the pharmacy recommendations for 07/2014 to ensure they were acted upon within fourteen (14) days of writing, per the policy and procedure. Interview with Team Leader (RN #5) on 09/25/14 at 9:55 AM, revealed she reviewed 100% of the pharmacy recommendations to ensure they were acted upon within fourteen (14) days of writing, per the policy and procedure. Interview with Team Leader (LPN #1) on 09/25/14 at 10:35 AM, revealed she reviewed 100% of the pharmacy recommendations to ensure they were acted upon within fourteen (14) days of writing, per the policy and procedure. Review of the facility's Pharmacy Recommendation Audit dated 07/2014, 08/2014, and 09/2014, revealed that 100% of all residents with pharmacy recommendations had the recommendations acted upon within fourteen (14) days. 3. Interview with the Consultant Pharmacist on 09/25/14 at 10:07 AM, revealed she met with the DON on 08/08/14 to review the correct practice of pharmacy recommendation and to train the DON on the newly revised practice. Interview with Team Leader (RN #5) on 09/25/14 at 9:55 AM, revealed she received training from the DON regarding the correct practice of pharmacy recommendations. Interview with Team Leader (LPN #1) on 09/25/14 at 10:35 AM, revealed she received training from the DON regarding the correct practice of pharmacy recommendations. Review of a facility inservice dated 08/08/14, revealed the RN/LPN Team Leaders were inserviced regarding the correct practice of pharmacy recommendations. 4. Interview with the DON on 09/25/14 at 1:01 PM revealed she monitors on a weekly basis for the timely response of the pharmacy recommendations by the physician to ensure they are addressed within fourteen (14) days. 5. Interview with the Consultant Pharmacist on 09/25/14 at 10:27 AM revealed she will continue to conduct monthly medication regimen reviews of all residents on antipsychotic medications and will make recommendations as deemed necessary. She further stated the DON has monitors in place to evaluate for compliance. 6. Interview with the Activities Director on 09/25/14 at 12:37 PM revealed she is a member of the QA Committee and has been informed of the progress and results of the audit tool and monitors in place at the facility. Interview with the Licensed Social Worker (LSW) on 09/25/14 at 12:42 PM revealed she is a member of the QA Committee and has been informed of the progress and results of the audit tools and monitors in place at the facility.