WV DHHR, Office of Health Facility Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507534	A. BUILDING: _____ B. WING _____	06/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT SENIOR LIVING AT CABELL MIDLA	100 WEATHERHOLT DR Ona, WV 25545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 003	Annual Licensure Survey June 23-25, 2008 Census: 65 Surveyors: Betty Marine LSW HFSII Ernie Chafin HFNSII Kathy Beauchamp HFNSII	E 003		
E 010	Deficiency Class Assignment In accordance with regulation 4.11.a, the classification for each standard (Class I, II, III) indicates the MOST SERIOUS DEFICIENCY CLASS that may be assigned to that regulation standard. In your Statement of Deficiencies (SOD) report, at the end of the regulation standard, you will note that each regulation indicates the highest deficiency class that may be assigned to this regulation when a deficiency is written (Class I, II, or III). Under the prefix ID column, you will note the actual class assigned to this deficiency based on survey findings on this specific survey date. What you may note is that a citation has been downgraded to a lower class, based on the deficient practice and survey findings. The Class assigned (in the Prefix ID column) will be the deficiency class that will determine your compliance with the licensing standards and issuance/renewal of your license. (A license cannot be issed until all Class I deficiencies are corrected)	E 010		

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	PLEASE NOTE: THE DEFICIENCY CLASS WILL NEVER BE UPGRADED TO A HIGHER CLASS!			
E 011	Plan of Correction In your PLAN OF CORRECTION (POC) you must: 1. Identify how you have corrected the problem identified by the deficient practice statement. 2. Identify how you have corrected the problem specific to any resident or employee named in the findings. 3. Identify how will you prevent the problem from occurring in the future for employees or residents. 4. Describe any policy or procedure you have developed to prevent recurrence of the deficiency. 5. Identify who will monitor the deficient practice to prevent recurrence and how often the monitoring will take place. 6. Include the expected COMPLETION DATE for all deficiencies identified on the report. 7. SIGN AND DATE YOUR POC and return within the specified timeline. Retain a copy of the report for your files.	E 011		

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E 201	64CSR14-7.4.b. Health Care Standards A prescription, written or verbal order from a professional authorized by state law to prescribe medications is required for obtaining, altering, discontinuing and administering or self-administering prescription and over-the counter medications, treatments, and therapies. The licensee shall keep copies of the prescriptions or written orders in the resident's record. (CLASS I) DEFICIENT PRACTICE and FINDINGS: 2. The record of resident #42 contains physician orders dated May 13, 2008, for Novolog 100U/ml inject sub q per SSI: Dose = BS-100/20 and accuchecks 4 times daily. The June 2008 MAR for this resident documents the accuchecks and sliding scale insulin administration but indicates no SSI is to be given at 8 p.m. Based on record review and interview on June 23-25, 2008, the administrator has failed to ensure that all physician orders for treatment have been consistently carried out for two (2) of eleven (11) resident records reviewed. 1. Resident #32 self-administers insulin with the aid of nurses. Physician orders indicate that the resident is to receive Lantus insulin 70 units every morning and Novolog insulin 30 units three (3) times a day before meals. In addition, this resident is to have Accu-checks performed four (4) times a day and daily weights. Documentation on the medication administration record (MAR) revealed the following: a. Blank spaces for the 70 units of Lantus were	E 201	June 23-25, 2008 1. These omissions on resident #32 were primarily by one nurse. We have discussed these omissions with this nurse. We have placed her on a 90 day probation. She states she understands the seriousness of these omissions. We have mandatory nurses meeting on July 22, 2008. We have a nurse manager from Amedysis coming to talk with us about documentation. We will be covering the survey and the deficiency of the missed documentation. 2. We talked with Dr. Steve Siebert about this order and he does want SSI to be given at the 8 p.m. A check. We explained to him what had been given and he said ok just start now with the SSI at 8 p.m. All of these issues will be discussed at our nurses meeting 7/22/08 and implemented 8/1/08. When RN's make weekly note they will be monitoring the MARs to make sure the nursing staff is initialling the MAR. Completion Date: August 1, 2008	08/01/08

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	found for the dates of June 7-9, 12, 18, 21 and 23, 2008. b. Blank spaces for the 30 units of Novolog for 12:00 p.m. on June 3, 8:00 a.m. and 12:00 p.m. on June 7-9, 8:00 a.m. and 12:00 p.m. on June 12, 2008. No documentation could be found for any of the doses for June 16, 18, 21 or 23, 2008. c. The results of the Accu-checks were not documented for 8:00 a.m. on June 21, 2008 or 11:00 a.m. on June 3, 18, and 21, 2008. d. Daily weights were not documented on June 7, 12, 16 and 21, 2008.			
E 223	64CSR14-7.6.f. Health Care Standards A registered nurse shall perform and document a nursing assessment for each resident with nursing needs within twenty-four (24) hours following admission, and update the assessment at the time of any significant temporary or permanent change in the resident's condition. (CLASS I) DEFICIENT PRACTICE and FINDINGS: 3. The record of resident #61, who received wound care and was on Coumadin therapy, documented that the resident experienced an uncontrollable nose bleed on May 24, 2008 requiring hospitalization. The resident returned to the facility on May 26, 2008. The hospital records indicated that the Coumadin exacerbated the nose bleed and recommended a dosage of 1 mg	E 223	June 23-25, 2008 1. As the administrator I understand this rule and our RNs will improve in charting our assessments of our residents. We chose to have 24 hour nursing because we feel our residents and their families feel better with the nurses here 24 hours a day allows our RN to rely on them for taking vital signs and reporting them and symptoms to the physician. The RN would not come in for s/s of a cold. We would tell the nurse to monitor for 24 hours and then call the physician for orders and then follow those orders. We will do better in documenting our communication with our nurses. 2. I misunderstood this rule. I did not know the RN had to make a note on the chart if the resident did not stay 24 hours. Again, with the 24 hours nurses	08/01/08

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	daily. On return to the facility the hospital discharge summary was faxed to the resident's physician asking the physician to okay the medications listed on the discharge summary before staff made changes to the resident's medication administration record (MAR). The physician reply did not come back to the facility until May 28, 2008, and indicated that the physician wanted the medications to resume as they were prior to hospitalization. During the interim between May 26-28, 2008, documentation by licensed staff indicated they did not administer Coumadin. Also, during this interim, the resident experienced another nose bleed on May 27, 2008. There was no documented assessment of the resident by a registered nurse during this interim and no documentation that anyone questioned resuming the previous Coumadin dose of 2 mg and 1.5 mg on alternate days on May 28, 2008, after the resident experienced a nose bleed while receiving no Coumadin. On May 29, 2008, the resident was again sent to the hospital for an uncontrollable nose bleed. Based on record review on June 23-25, 2008, the administrator has failed to ensure that the registered nurse assessed three (3) of nine (9) residents who experienced a significant change in condition. 1. Resident #5 complained of cold symptoms and not feeling well on on December 11 2007. On December 14, 2007 documentation indicates that chest x-ray results were faxed to the physician. On December 15, 2007, new orders were noted due to a diagnosis of pneumonia. Documentation of an RN assessment was not found until December 17, 2007 and failed to include any assessment regarding the recent		the RN did not chart when the LPN did or can. Again, our communication with the LPN was not charted. 3. Our nursing staff did not question the coumadin restart because we were aware that the physician and the resident were in agreement that the coumadin was not an issue with the nose bleeds. I understand the RN should have documented the conversation between physician and resident concerning coumadin and nose bleeds. Will talk with all nurses to stress talking closely with physicians and documenting what is being discussed. Completion Date: August 1, 2008	

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	diagnosis of pneumonia. 2. Resident #15 experienced a large amount of black emesis on May 8, 2008, was sent to the emergency room for evaluation and returned to the facility on the same day. An RN assessment had not been documented as of May 15, 2008.			
E 225	64CSR14-7.6.h. Health Care Standards A registered nurse shall see the resident weekly and more often if indicated by the needs of the resident, and document a progress note in the resident's record reflecting the status of the resident and any changes in his or her condition. (CLASS II) DEFICIENT PRACTICE and FINDINGS: 2. a. The records of resident #'s 37 and 61, both receiving ongoing treatment for leg ulcers, failed to contain weekly documentation by the registered nurse containing a description of the wounds or response to treatment. Nor were notes available from the wound clinic or home health agency that residents provided wound treatment to the residents. b. Registered nurse RB stated on June 25, 2008, that she did not address the status of these resident's wounds in the weekly notes because the residents went to a wound clinic and home health dressed the wounds. She said they did not receive weekly notes from the clinic or the home health agency documenting description and	E 225	June 21-25, 2008 RN aware that a weekly note is needed for all skilled residents. Will be more careful of assessing all skilled residents. All RNs will monitor charts and MARs for charting being done. Completion Date: August 1, 2008	08/01/08

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	status of the wounds. Based on record review and interview on June 23-25, 2008, documentation of a weekly registered nurse's note was inconsistent for five (5) of eight (8) resident records reviewed with a diagnosis of insulin dependent diabetes and the weekly notes for two (2) of two (2) residents with wound care failed to address the status of wounds. 1. Weekly notes by the registered nurse were not found for the following insulin dependent residents: a. Resident #22 from October 25 through November 16 and from November 19 through December 5, 2007. b. Resident #5 from January 10 through January 25 and February 27 through March 14, 2008. c. Resident #13 from January 10 through January 25, 2008 and from February 27 through March 14, 2008. d. Resident #15 from November 11 through December 4, 2007. e. Resident #23 from May 23 through June 6, 2008.			