Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100020	A. BUILDING: _____ B. WING _____	R-C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN KY MEDICAL CENTER	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

(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 000}	Initial Comments An on-site revisit and complaint investigation (KY29611) was conducted on 05/07-09/19. The complaint was substantiated. The facility continued to be out of compliance with tags E0041 and E2340, and additional deficient practice was identified at E0020, E0330, E0610, and E2920.	{E 000}		
E 020	902 KAR 20:016 3(1-2) Section 3. Administration and Operation (1) Governing authority licensee. (a) The hospital shall have a recognized governing authority that has overall responsi-bility for: 1. The management and operation of the hospital; and 2. Compliance with federal, state, and local law pertaining to its operation. This requirement is not met as evidenced by: Based on interview, record review, and review of Governing Body Meeting Minutes, facility audits, Daily Operating Budget, and the Plans of Correction the facility submitted for the Statement of Deficiencies dated 01/30/19 and 03/12/19, it was determined that the facility failed to ensure the Chief Executive Officer (CEO) was responsible for managing the hospital budget and implementing the Plan of Correction. On 01/30/19, Immediate Jeopardy was identified at the facility. The facility submitted a Plan of Correction (POC) and alleged compliance. However, a revisit on 03/12/19 revealed non-compliance with the Conditions of Participation (COP) at Governing Body, Quality Assessment and Performance Improvement, and Nursing Services continued. The facility	E 020	The governing board met 5/30/19, appointing a Vice Chairman. The current chairman of the board and owner of Southeastern KY Medical Center will no longer have authority or voting ability r/t day to day operations of the facility. The owner/chairman will only be involved for the sale or liquidation of assets. A new entity was engaged two weeks ago for the transfer of ownership of the assets, including the CON, license, and other assets within the facility. A change of ownership is expected to be finalized by early next week. (See attached board minutes) A 90-day budget was developed to reflect how the facility will meet the needs for operational cost, payroll, pharmacy needs, ED provider coverage, and supplies. (See attached budget). An understanding with the ED provider vendor, pharmacy vendor, EMR vendor, and supply vendor has been established to continue a relationship with the facility with the involvement of a new entity along with the impending transfer of ownership next week. The facility is purchasing supplies without interruption. A copy of the pharmacy transaction is attached showing the facility's ability to order medications from the pharmacy vendor. To show no lapse in coverage for the ED, the provider group is attached. The ED vendor has received a daily amount agreed upon and will continue with ED coverage. There has been no in interruption of Emergency Department coverage see Emergency Department provider schedule and vendor contact information if verification is needed. Payment plan will be in place with all lab vendors which will give the facility the ability to order supplies needed to perform in-house test.6/11/19	6/11/19 6/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim CEO — (X6) DATE: 5-22-19

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E 020	Continued From page 1 submitted a second Plan of Correction (POC) and alleged compliance effective 04/14/19. However, a second revisit on 05/09/19 revealed non-compliance continued at the COPs and Immediate Jeopardy was identified. In addition, Immediate Jeopardy was identified at the COPs for Laboratory Services and Infection Control. The findings include: Review of the Chief Executive Officer's (CEO) Job Description and Performance Standards, undated, revealed the CEO/Administrator shall be the Governing Board's representative in the management of the facility. The CEO shall be given the necessary authority and responsibility to operate the facility in all its activities and departments, subject only to such policies as may be issued by the Governing Board or by any of its committees to which it has delegated power for such action. The CEO shall act as the duly authorized representative of the Governing Board had not formally designated some other person to act. Review of a Statement of Deficiencies dated 01/30/19 revealed Immediate Jeopardy was identified at the Conditions of Participation (COP) for Governing Body (CEO and Budget); Patient Rights; Quality Assurance and Performance Improvement; Nursing Services; Discharge Planning; Surgical Services; and Emergency Department Services. The facility submitted a Plan of Correction and alleged compliance with the COPs effective 03/08/19. However, a revisit conducted on 03/12/19 revealed the facility continued to have noncompliance with the COPs at Governing Body; Quality Assurance and Performance	E 020		

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E 020	Continued From page 2 Improvement; and Nursing Services. Review of Board of Directors Meeting Minutes dated 04/02/19 revealed the board met to discuss the current "J" (Immediate Jeopardy) tags and the Corrective Action plan submitted on 03/29/19. Continued review of the Board of Directors Meeting Minutes revealed the CEO reported that he was working to amend the budget to include repayment of outstanding debt, which included all vendor debt and the repayment schedule for tax liabilities. The CEO requested Board approval for the addendum to the budget, and the motion passed unanimously. The meeting minutes also indicated a Quality Improvement Director had been hired and the facility was working to improve Quality Assessment. Quality Meetings were being held weekly with a Board member and physician in attendance. According to the minutes, quality reports and information that were shared with the Board had shown improvement. The CNO reported that daily chart audit tools had been revised to include detail to better capture medication errors. The minutes stated the CNO also indicated that in-services and education were continuing with Nursing Staff regarding the nursing "J" [jeopardy] tags. Review of the Board of Directors Meeting Minutes dated 04/11/19 revealed the CEO amended the facility's budget to include the outstanding debt as required by the "state" for the corrective action plan. The Minutes revealed that the CEO had "prepared a repayment schedule for the tax liabilities and [pharmacy vendor]." The meeting minutes stated a discussion ensued regarding the current "liabilities and the payroll issues." The owner of the facility stated the pharmacy vendor "would be paid within six months and the funds would come from [Americore] and [St. Alexius, a	E 020		

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E 020	Continued From page 3 facility in another state], he indicated the plan would be to pay the tax liabilities from the RHC (Rural Health Clinic) Medicaid rate adjustment. Responding to the payroll issue [the owner] stated we will work to improve business operations to ensure payroll is stable." The facility submitted a second POC and alleged compliance effective 04/14/19. However, during a revisit on 05/07/19, interviews with staff and review of medical records, facility policies, audit tools, and Performance Improvement Minutes revealed the facility failed to implement the Plan of Correction and Immediate Jeopardy was identified again at Governing Body; Quality Assurance and Performance Improvement; and Nursing Services. In addition, Immediate Jeopardy was also identified at Infection Control and Laboratory Services. Interview with the CEO on 05/08/19 at 5:30 PM revealed he did not have funds to make payments on outstanding debt and to fund the daily operations of the facility. Currently, the CEO stated he could not pay the Emergency Department physician vendor on 05/10/19 and there was the possibility that the facility would not have physician coverage for the ED. Further interview with the CEO revealed the facility had not met payroll for the pay period ending on 04/26/19 and at the time of the interview, he did not have the funds to meet pay roll on 05/10/19. The CEO stated the facility still owed the health insurance vendor, but was attempting to negotiate a settlement for continued coverage for employee health benefits. Continued interview with the CEO revealed the facility had discussed the fact that some laboratory supplies could not be re-purchased and some laboratory services were being "out sourced" to another laboratory.	E 020		

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E 020	Continued From page 4 The CEO stated he was aware that the procedure had resulted in a delay in obtaining results of tests, which in turn delayed treatment for facility patients. Continued interview with the CEO revealed he could not access any funds for the facility without approval from the owner of the facility. The CEO stated that the owner had applied for a "bridge" loan to assist with funding the facility; however, the loan was not approved and the facility did not have adequate funds to operate on a day to day basis. Further interview with the CEO revealed he did not know how the facility planned to continue to operate without funds. According to the interview with the CEO, he was not aware that the facility was not conducting audits as stated in the facility's Plan of Correction and was not aware that audits were not effective in identifying quality of care issues. Review of Board of Directors Meeting Minutes (Special Called Conference Call) dated 05/02/19 revealed a special meeting was called to discuss the election of a new board member (Physician #5), to inquire whether the State Agency had returned for a revisit, and to question if the facility Geriatric Psychiatric Unit had reopened. Continued review of the minutes revealed another meeting was set for 05/07/19 at 5:00 PM. Further review of the minutes revealed no documented evidence the facility discussed the facility's budget and/or the inability to pay for continued operation, that payroll could not be met on 04/26/19, or the progress of the facility's compliance with the Conditions of Participation. Post survey interviews with the ED contract vendor on 05/13/19 at 2:55 PM 3:45 PM revealed the vendor received payment from the facility on	E 020		

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E 020	Continued From page 5 05/10/19 and continued to provide physician coverage for the facility's ED through the weekend; however, the vendor sent a letter to the facility on 05/13/19 suspending physician coverage of the ED because payment had not been made. A post survey interview with CNO on 05/13/19 at 3:15 PM revealed the facility did not have the funds to meet payroll again on 05/10/19, resulting in staff not being paid for one month. A post survey interview with the Pharmacy supply vendor on 05/14/19 at 11:25 AM revealed the facility currently had an outstanding debt of $481,754.86 in the "pharma" account and $23,335.79 in the "medical" account. The Pharmacy Supply Vendor stated the facility's account was evaluated on the 20th of every month to review payments made on the account and to determine if the Pharmacy Supply Vendor would continue to supply the facility with medications/supplies. Continued interview with the pharmacy vendor revealed the facility's "account is now flagged for a hold" - meaning [they] "will not be accepting any more orders from [the facility] nor shipping product to them." Further interview revealed the vendor had "shut them" off briefly a few times in the past until payments were made. The Pharmacy Vendor stated the facility had "set up payments with [the vendor] for the 20th of each month which have stopped as well as a pre-payment option, which [had] also not worked."	E 020		
{E 041}	902 KAR 20:016 3(2)(a)2 Section 3. Administration and Operation (2) Administrator.	{E 041}		

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(E 041)	Continued From page 6 (a) The administrator shall: 2. Be responsible for the management of the hospital; This requirement is not met as evidenced by: Based on interview, review of the facility's Budget policy, review of the facility's vendor balances, review of Statements of Deficiencies (SOD) issued to the facility and the facility's corresponding Plans of Correction (POC), it was determined the facility failed to ensure an annual operating budget was prepared according to generally accepted accounting principles. Deficient practice was identified at the facility on 01/30/19 related to the facility's failure to develop a budget. A revisit conducted on 03/12/19 revealed non-compliance continued related tothe facility's failure to ensure the budget was prepared in accordance with generally accepted accounting principles. The facility submitted a second POC and alleged compliance with the Condition of Participation effective 04/14/19. However, non-compliance was determined to continue. Even though the facility revised the budget to include payment toward outstanding debt, review of the budget and an interview with the CEO revealed the facility did not have the funds to cover outstanding debt and day to day operation. Review of the facility's Vendor Balances revealed the facility owed vendors $4,762,937.88; subsequently, the vendor that provided physicians for the Emergency Department and the vendor who provided pharmaceutical supplies terminated their contracts with the facility. In addition, the facility had an outstanding tax debt of $1,189,274.97 and did not meet employee payroll on 04/26/19 or 05/10/19 due to the unavailability of funds.	(E 041)	Completion of the CHOW is pending. After completion of the transaction a new hospital administrator will be appointed to oversee the daily operations and implementation of the plan of correction as well as ensure that quality of care is maintained. A hospital wide policy implementation was approved May 30th, 2019 from QAPI Council (see attached policy) which will ensure appropriate action is taken when policy violation occurs. Sent to MEC and Governing Board for approval. Education of staff will occur with each violation, with documentation available to support the identified occurrence as required. The owner of Southeastern KY Medical Center has been removed from the day to day operations of the facility, (see attachment of court order and from the Governing Board as a voting member). The owner's input to the board is only regarding assets and liquidation of the facility. A Vice Chairman of the board was appointed 5/29/19 (see board minutes attached).	6/11/19 6/11/19 6/11/19

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{E 041}	Continued From page 7 The findings include: Review of the facility's policy, "Strategic Plan, Operating Budget, and Three (3) Year Capital Expense Budget," dated February 2019, revealed the Hospital Administration would initiate, develop, and complete an annual strategic plan, operation budget, and three-year capital expense budget that would be forwarded to the Medical Executive Committee and Board of Directors for approval. Review of a Statement of Deficiencies (SOD) dated 01/30/19 revealed Immediate Jeopardy was identified at the Governing Body Condition of Participation because the facility failed to have an overall institutional plan with an annual operating budget that included all anticipated income and expenses, and contained capital expenditures for a three-year period. Further review of the SOD revealed observations and interviews with staff revealed the facility failed to have adequate supplies, equipment, or medications to adequately care for patients due to budgetary constraints and the facility's inability to obtain cash flow to purchase needed items. The 01/30/19 SOD revealed the facility owed their supplying pharmacy approximately one-half million dollars, and their electronic medical records vendor approximately six hundred thousand dollars, and all vendors supplying the facility were refusing to provide services and goods without prepayment payments. The facility submitted a Plan of Correction and alleged effective 03/06/19 the facility would be back in compliance. However, review of a SOD dated 03/12/19 revealed the facility failed to achieve compliance	{E 041}	Attached is an ED Physician Schedule which reflects no lapse of coverage has occurred at any time in our ED. The ED Physician vendor and the Facility management has agreed upon financial reimbursement to satisfy the coverage required to provide uninterrupted service. (see attached) Payment plan will be in place with all lab vendors which will give the facility the ability to order supplies needed to perform in-house test if needed. The health insurance vendor is current, and employees have continued coverage (see attached receipt of payments for May 2019.	6/11/19 6/11/19 6/11/19

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{E 041}	Continued From page 8 effective 03/06/19 and non-compliance continued due to the facility's failure to ensure the annual operating budget was prepared according to generally accepted accounting principles. Review of the facility's budget revealed the facility failed to ensure the budget included repayment of outstanding debt and failed to fully disclose the hospital's monetary situation. The facility failed to pay employee taxes (federal, state, and city) for the 4th quarter of 2018; employee taxes for February 2019; and owed $377,000 to the Pharmacy Supplier. However, the facility failed to include the debt in their budget. Further, as of 03/12/19, funds were not available to meet payroll due on 03/15/19. In addition, the budget included revenue ($99,000 per month from January through June 2019) for income that will not be received until November 2019 (the next fiscal year). The facility submitted a Plan of Correction in response to the SOD and alleged the facility would be in compliance with a correction date of 04/14/19. The facility's POC stated, "The budget was approved by the Governing Board on 02/26/19. An addendum will be added to include repayment of outstanding debt, which includes all vendor debt and the repayment schedule for tax liabilities. The Board has approved agreements with taxing authorities to ensure liabilities are met, see board minutes." Review of the "Operating Budget" for the period ending 06/30/19, "as a Preliminary Draft as of 8/3/18", revealed the facility revised the budget to include $200,000-$300,000 each month for the "Provision for Bad Debt" as stated in the facility's POC. In addition, the facility's budget revealed allowances were made for salaries and wages, employee benefits, physician fees, and supplies. However, according to the budget, the facility had a "Net Operating" loss each month from July	{E 041}		

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(E 041)	Continued From page 9 2018 through April 2019 that ranged from $13,495 in April 2019 to $435,277 in July 2018. Review of the "Vendor Balances" spreadsheet dated 05/07/19 revealed the facility had outstanding balances to the pharmacy vendor in the amount of $469,564.15 for one account, a second account in the amount of $27,584.54, a third account in the amount of $18,428.40, and a fourth account in the amount of $97,444.81; Kentucky Unemployment Insurance Fund in the amount of $9,474.83, and a second account in the amount of $328,442.56; Electronic Medical Record Vendor in the amount of $795,950.01; Laboratory Corp of America in the amount of $51,612.75; Baxter Health Care (a medical and pharmaceutical vendor for intravenous medication supplies) in the amount of $41,756.90; Kentucky State Treasurer in the amount of $859,837.17, and a second account in amount of $109,015.50; Omnicell (medication vendor) Inc. in the amount of $174,181.51; the Emergency Department (ED) physician group in amount of $85,109.67; and Medius Radiology Services in the amount of $26,600.00. Further review of the vendor balance sheet revealed the total balance owed to all vendors was $4,762,937.88. Review of the Gross Wages and Tax Liability for fiscal year 2019 revealed the facility had not paid federal taxes for fourth quarter of 2018 and had an outstanding debt of $356,706.79, and had an outstanding debt of $401,738.14 for federal taxes for the first quarter of 2019, for a total debt of $933,052. Continued review revealed the facility owed Total Withholding Taxes in the amount of $1,189,274.97. Interview with the Chief Executive Officer (CEO)	(E 041)		

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(E 041)	Continued From page 10 on 05/08/19 at 5:20 and 5:50 PM revealed he had been making minimum payments on the tax liabilities debt; however, when he paid the tax debt, he could not continue to pay a $5,000 per day debt to the vendor who staffed the facility's Emergency Department with physicians. The CEO stated if he could not pay the Emergency Department physician vendor $30,000 by the close of business on 05/10/19, the vendor would not provide a physician for the facility's ED beginning at 7:00 PM on 05/10/19. Further interview with the CEO revealed the facility had not met payroll for the pay period ending on 04/26/19 and at the time of the interview, he did not have the funds to meet pay roll on 05/10/19. The CEO also stated even though the facility had taken money from employees' wages to pay for health benefits, the facility employees had no health benefits for the months of November and December 2018 because the facility had not paid the health insurance company for the employees' premiums. The CEO stated the facility still owed the health insurance vendor, but was attempting to negotiate a settlement for continued coverage for employee health benefits. Continued interview with the CEO revealed the facility had discussed the fact that some laboratory supplies could not be re-purchased and some laboratory services were being out sourced to another laboratory facility. The CEO stated he was aware that the procedure had resulted in a delay in obtaining results of tests, which in turn delayed treatment for facility patients. Further interview revealed out of state taxes for two (2) employees had not been paid for 2018 and the CEO was assisting those employees with personal audits due to the facility's non-payment of their taxes.	(E 041)		

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(E 041)	Continued From page 11 Further interview with the CEO revealed he did not have access to any funds for the facility without approval from the owner of the facility. The CEO stated that the owner had applied for a "bridge" loan to assist with funding the facility; however, the loan was not approved and the facility did not have adequate funds to operate on a day to day basis. In addition, the CEO stated the facility had little revenue because for an unknown reason, the facility had not received any reimbursements from funding sources for approximately six weeks. The CEO did not comment on a plan to repay the $4,762,937.88 listed on the facility's Vendor Balance spreadsheet. Post-survey interviews with the ED contract vendor on 05/13/19 at 2:55 PM and 3:45 PM revealed in order to provide physician coverage for the facility's ED, the facility had to pay the vendor $5,000.00 per day. Failure to receive payment would result in suspension of physician coverage. The vendor representative stated the vendor received a payment from the facility on 05/10/19 (Friday) and the vendor continued to provide physician coverage for the facility's ED through the weekend; however, the vendor sent a letter to the facility on 05/13/19 suspending physician coverage of the ED due to the facility's failure to make a $5000.00 payment. Continued interview revealed physician coverage of the ED had been suspended in the past on 11/06/18 through 11/07/18 at 11:00 AM, on 11/27/18 through 11/28/18 at 1:00 PM, and on 12/29/18 through 12/31/18 at 12:15 PM. A post-survey interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed the facility planned to continue to provide ED services, despite being unable to pay the vendor	(E 041)		

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{E 041}	Continued From page 12 for physician coverage. The CNO stated a staff physician planned to stay at the facility and provide ED services if a "deal" could not be worked out with the current vendor. Further interview with the CNO revealed the facility did not have the funds to meet payroll again on 05/10/19, resulting in staff not being paid for one month. A post-survey interview with the Pharmacy Supply Vendor on 05/14/19 at 11:25 AM revealed the facility had an outstanding debt of $481,754.86 in one account ("pharma") and $23,335.79 in a "medical" account. The Pharmacy Supply Vendor stated the facility's account was evaluated on the 20th of every month to review payments made on the account and to determine if the Pharmacy Supply Vendor would continue to supply the facility with medications/supplies. Continued interview with the pharmacy vendor revealed the facility's "account is now flagged for a hold" - meaning [the vendor] "will not be accepting any more orders from [the facility] nor shipping product to them." Further interview revealed the vendor had "shut them" off briefly a few times in the past until payments were made. The Pharmacy Vendor stated the facility had "set up payments with [the vendor] for the 20th of each month which have stopped as well as a pre-payment option, which [had] also not worked." A post-survey interview with the Pharmacy Supply Vendor on 05/15/19 at 4:47 PM revealed the Pharmacy vendor confirmed the facility "still is on hold and [the Pharmacy Vendor was] not accepting any more payment arrangements or orders at this point."	{E 041}		

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E 330	Continued From page 13	E 330	A QAPI chart audit tool was developed after the 1/30/2019 survey. The lack of measuring indicators on the original tool utilized did not effectively capture the entire record. A QAPI consultant was hired on 3/19/2019 and a QAPI plan was developed and implemented at that time. Weekly PI meetings were held. Audits were completed on 4/29/2019, 4/30/2019, and 5/02/2019. See the attached e-mail confirmation to the OIG for chart audits.	6/11/19
E 330	902 KAR 20:016 3(8)(b)1-2 Section 3. Administration and Operation (8) Medical staff. (b) The medical staff shall be responsible: 1. To the governing authority for the quality of medical care provided to the patients; and 2. For the ethical and professional practice of its members. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's Statements of Deficiencies and Plans of Correction for a survey visits on 01/30/19 and 03/12/19, the facility's Quality Improvement Plan, and the facility's audits and Performance Improvement (PI) Minutes, it was determined the facility failed to conduct audits as required by the facility's Quality Improvement Plan and Plan of Correction. Deficient practice related to the facility's failure to implement and maintain an effective Quality Assurance and Performance Improvement Program (QAPI) was identified on 01/30/19 and 03/12/19. The facility submitted two Plans of Correction and alleged compliance on 04/14/19; however, continued non-compliance was identified related to the facility's failure to monitor the effectiveness of the quality of care provided, failed to revise action plans to address quality of care concerns that were identified through the PI program, and failed to ensure audits were effective in identifying quality of care concerns related to Patients #25 and #27. The findings include: Review of the facility's 2019 Quality Improvement Plan signed 03/05/19 revealed the areas included	E 330	On 3/9/2019, a revised tool was implemented to accurately capture data for the 24-hour time frame. The revised tool was also found to be ineffective based on the re-survey in May of 2019. The QAPI committee met on 5/30/2019 to address the SOD from CMS. Based on the findings, a hospital wide policy was developed to address issues when employees where not following specific policies. This policy will address issues with nursing documentation, medication administration issues or any other quality of care concerns. A revision to the chart audit tool has been completed. The new chart audit tool has been improved to be more informative of the overall documentation and has eliminated the inconsistencies in previous chart audits. Pharmacy will utilize a tracking tool for all medication errors. See attached QAPI minutes for the new policy, and pharmacy tracking tool. On 5/30/2019, the Medical Executive Committee met and discussed the SOD and the CAP in progress. The committee reviewed the QAPI's plan to implement a new chart auditing tool and discussed and approved a new policy for discipline for all employees that do not follow policy. With the implementation of this policy, Human Resources and Managers will effectively be able to hold employees accountable for their actions.	6/11/19 6/11/19 6/11/19

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E 330	Continued From page 14 in the Scope of the program were high risk, high volume or problem prone processes; infection control; restraint and seclusion use; mortality review; blood and blood product use; organ procurement; utilization review; data management; measures related to regulatory requirements, etc. The plan also listed the committee members, the process improvement framework and reporting format. 1. Review of a Statement of Deficiencies (SOD) dated 01/30/19, revealed Immediate Jeopardy was identified due to the facility's failure to implement and maintain an effective ongoing, hospital-wide, data-driven Quality Assurance and Performance Improvement (QAPI) Program. Interviews with staff revealed the facility had not conducted any QAPI activities since July 2018. Subsequently, review of patient records and interviews with staff revealed the facility failed to identify patient care and patient safety concerns and failed to develop action plans to address the concerns. The facility submitted a Plan of Correction (POC) and alleged compliance with the QAPI Condition of Participation effective 03/06/19. However, review of a SOD dated 03/12/19 revealed non-compliance continued due to the facility's failure to ensure that performance indicators and audits were collected and reviewed per the Quality Improvement Plan and per the Plan of Correction. The 03/12/19 SOD revealed the facility did not conduct audits as stated in the plan and did not identify concerns with omitted/missed doses of medications involving Patient #16 and Patient #13. Review of a second Plan of Correction submitted for the 03/12/19 revealed the facility alleged that	E 330	To address and correct the issue of nursing not being aware of urine culture results, licensed nursing staff will review their specific patient's labs each shift and check for abnormal or pending lab results. The Infection Control Nurse will perform surveillance to ensure that the nurse is checking for lab results and she will keep a log of compliance. See copy of surveillance log attached. To address the nursing staff failing to identify and treat the patients diabetic foot ulcer and follow hospital nursing assessment policy, the QAPI committee has developed a new policy that will take appropriate action for nursing staff for not following policies. Upon approval of this policy, nursing staff will be in-serviced on the new policy and the actions that will be taken if policies are not followed. To address patient #26 who was admitted on 5/07/2019 at 10:30am, patient had labored breathing with no oxygen administered. The SOD stated, the patient had been there for awhile and the patient had not been evaluated by the nursing staff. The patient was in the facility on the in-patient medical-surgical floor because this is where the facility places all outpatients or (OPD patients). The MD order states the patient was admitted to an OPD bed. Because this patient was for an OPD bed and not an observation patient nor an inpatient, the Initial Physical Assessment was not required, instead an OPD flowchart was required and initiated. See attached MD order. The nurse contacted the MD and a MD telephone order was obtained for oxygen at 11:15am. Later that evening, the patient was converted from an OPD status to an observation status, see attached MD telephone order. After the patient was converted to observation status, the initial physical assessment and initial interview were completed per policy guidelines at 5:48pm. See attached copy of nursing admission documentation and patient admission policy.	6/11/19 6/11/19 6/11/19

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E 330	Continued From page 15 they would be in compliance with the QAPI Condition of Participation effective 04/14/19. Review of the POC revealed, "The chart audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day ... Medication errors will be reported [through] a paper report to the Risk Management committee to monitor patterns or trends." The facility alleged in the Plan of Correction that compliance would be achieved effective 04/14/19. However, review of the facility's Nursing Medical-Surgical Audit Tool (24 hour) revealed there was no documented evidence that the facility completed an audit as stated in the Plan of Correction on 04/29/19, 04/30/19, 05/01/19, or 05/02/19 to ensure compliance was maintained. Review of the facility's Performance Improvement (PI) Minutes dated 04/30/19 revealed no documented evidence that the facility discussed the daily audits not being conducted as planned. Further review revealed 35 medical record audits had been conducted and 26% of the records had an omission medication error, and 6% of medications were administered at the wrong time. Further review revealed the physician had not been notified of any of the omission medication errors. Continued review of the PI minutes revealed there were 34 nursing errors that included the following: 11% of the records revealed an initial interview was not completed within 1 hour of admission, a pain assessment not completed 32% of the time, critical laboratory results were not reported in a timely manner5.26 % of the time, nutrition screening not completed	E 330		

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E 330	Continued From page 16 11%, physician not notified of a change of status 42% of time. However, there was no documented evidence the facility developed a plan of action to address the concerns identified during the PI Meeting. A post-survey interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed she was "not sure" why chart audits had not been completed as stated in the facility's Plan of Correction. Continued interview with the CNO revealed the facility did not develop any type of action plan after the PI meeting, other than to educate which was not a new intervention. However, review of the minutes revealed that education had not been effective in ensuring compliance with medications errors and critical laboratory results, notification of change in condition, nor nursing documentation. 2. Review of the facility policy titled, "Medication Administration" approved August 2017, revealed antibiotic medications were time-critical scheduled medications and early or late administration could have a significant negative impact on the intended pharmacological or therapeutic effect of the medication. The policy stated antibiotics would be administered to the patient within thirty minutes before or after the scheduled dosing time, for a total window of one hour. Review of the medical record for Patient #27 revealed the facility admitted the patient on 05/02/19 with a diagnosis of Dyssomnia, Sleepless, Exhaustion, Pale, Orthostatic, and Generally not well. Review of Physician Orders for Patient #27 dated 05/03/19 at 4:40 PM revealed the patient had an	E 330		

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E 330	Continued From page 17 order for intravenous (IV) Ampicillin (antibiotic) every six (6) hours. Review of Patient #27's Medication Record revealed staff administered IV Ampicillin on 05/04/19 at 8:00 PM, and again on 05/05/19 at 12:56 AM, (34 minutes before the dose could be given according to the facility's policy). Review of the facility's audit tool titled, "Nursing Medical-Surgical Audit Tool (24 hour)" dated 05/04/19 to 05/05/19 revealed the facility reviewed Patient #27's medical record and documented there were "no issues" with the patient's medication. There was no documented evidence the facility identified that staff administered Patient #27's medication prior to time the dosage was due to be administered. 3. Continued review of the facility's "Nursing Medical-Surgical Audit Tool revealed the facility was monitoring to ensure the physician was notified timely of critical tests/results and any change in a patient's condition. Review of the Plan of Correction (POC) the facility submitted for the Statement of Deficiencies (SOD) dated 03/12/19 revealed "The chart audit tool was revised to include more detail and better capture medication errors ..." According to the Nursing Medical-Surgical Audit Tool, the facility was monitoring the types of medication errors, which included wrong dose, wrong medication, etc. and "diagnostic/treatment measures required". Review of Patient #25's medical record revealed the facility admitted the patient on 05/01/19 under the services of MD#5 with diagnoses of Urinary Tract Infection (UTI) with gross hematuria (blood	E 330		

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E 330	Continued From page 18 in urine), uncontrolled Diabetes, and Hypertension. Review of Patient #25 Admitting physician orders revealed staff were directed to collect a urine culture with sensitivity on 05/01/19. Further review of Patient #25's medical record revealed Physician #5 ordered Levaquin (or Levofloxacin, an antibiotic) 250 milligrams (mg) intravenous (IV) daily and Bactrim (antibiotic combination of sulfamethoxazole and trimethoprim) 400-80 mg one tablet daily. Review of Patient #25's laboratory reports revealed the facility collected a urine culture on 05/02/19 at 2:49 AM, and the final report dated 05/05/19 at 3:35 PM, revealed the patient had a Multidrug-Resistant organism (MDRO), Extended-spectrum beta-lactamase (ESBL) in his/her urine. Review of the sensitivity report revealed the organism was resistant (would not respond) to Levaquin or Bactrim antibiotics that the patient was receiving at the facility. However, further review of Patient #25's medical record revealed no evidence that the urine culture report had been reviewed or any action had been taken based on the report to ensure the patient was receiving a medication that was susceptible to the patient's infection. 3. b. Further review of the facility's Nursing Medical-Surgical Audit Tool revealed the facility was monitoring to determine whether a decubitus ulcer was present on admission and if so, the decubitus ulcer performance improvement form was required. Continued review of Patient #25's medical record revealed prior to admission to the facility on 05/01/19, MD #5 evaluated the patient in his	E 330		

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E 330	Continued From page 19 office. MD #5 documented that the patient had burning pain and numbness to both feet and an ulcer to the right foot that had been previously debrided. The progress notes also revealed Patient #25 was status post amputation to his/her great and second toe on the left foot. However, review of Patient #25's Admission Nursing Assessment dated 05/01/19 at 3:56 PM revealed Registered Nurse (RN) #7 documented that the patient had no abnormal skin integrity impairments and the patient's neurological system and pulses were within normal limits. There was no documented evidence the facility identified and/or assessed the ulcer to Patient #25's left foot until 05/03/19, two days after admission to the facility. Review of the nurse's notes dated 05/03/19 (two days after admission) at 11:56 AM revealed RN #4, documented that Patient #25 had an "old debridement area, open round area surrounded by extremely thick dry skin noted white/pale yellow area noted with dark area on the side, small amount of clear yellow drainage noted," to his/her right foot. Review of Physician #3's documentation (the facility surgeon) revealed he evaluated Patient #25 on 05/07/19 and the patient had "ongoing open wound" to his/her right foot with a osteomyelitis (infection of the bone), which appeared to be "settling down" In addition, according to the documentation, even though staff documented the Patient #25's pulses were within normal limits on admission, the surgeon documented that the patient did not have a pulse in the patient's right foot (dorsalis pedis).	E 330		

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E 330	Continued From page 20 Continued review of the Audit tools revealed the facility reviewed Patient #25's medical record on 05/02/19, 05/03/19, 05/04/19 and 05/05/19, and the facility identified no issues with the patient's skin integrity, medications, nor physician notification regarding critical tests/results and/or change of status. Continued interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed she thought the facility was auditing 100 percent of all medical records and was unaware of the identified concerns. The CNO also stated she was unsure why the concerns were not identified during the audits of the patients' medical records because she was under the impression that everything in the records were being reviewed.	E 330		
E 610	902 KAR 20:016 3(10)(d)1h Section 3. Administration and Operation (10) Physical and sanitary environment. (d) The infection control policies shall address the: 1. Prevention of disease transmission to and from patients, visitors, and employees, including: h. Reporting, investigating, and controlling outbreaks of healthcare-associated infections; This requirement is not met as evidenced by: Based on observation, interview, record review, review of facility policy, and review of the facility Infection Control Log, it was determined the facility failed to ensure that the infection control officer had a system for identifying, reporting, and controlling infections of patients and personnel for	E 610	To address the infection control issue with patient #25, upon obtaining any results, including results received through an electronic file form an outsourced laboratory, results will then be forwarded from the laboratory personnel to the Infection Control nurse and the patient's primary nurse and physician. The infection control nurse will then place results on the tracking log. The infection control nurse will then review the inpatient or observation patient records to ensure that the patient is on the appropriate antibiotic. In the event that an outpatient result requires physician notification, the infection control nurse will do a follow-up with the physician's office to determine and ensure that the patient has received appropriate treatment.	6/11/19

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E 610	Continued From page 21 one (1) of twelve (12) sampled patients (Patient #25). Review of the medical record revealed Patient #25 was admitted to the facility on 05/01/19, with a diagnoses of Urinary Tract Infection (UTI) with gross hematuria (blood in urine). Review of Patient #25's lab results, dated 05/05/19 revealed the patient had a Multidrug-Resistant organism (MDRO), Extended-spectrum beta-lactamase (ESBL) in his/her urine (ESBL is an infection that is resistant to many antibiotics and is spread by contact with infected person or by contact with contaminated surfaces). However, review of the medical record on 05/07/19 revealed no evidence the patient's Physician had been notified of the lab results and no evidence that action had been taken to prevent the spread of the infection to other patients. In addition, further review of Patient #25's medical record revealed he/she had a history of ESBL infection of a wound that was diagnosed on 03/29/19; however, interview with the Infection Control Nurse on 05/08/19 at 3:00 PM, and review of the facility's Infection Control Tracking Log revealed no evidence Patient #25's abnormal culture results were included on the tracking log. The Findings Include: Review of the facility policy titled, "Transmission Based Isolation Precautions," approved February 2017 revealed all patients suspected of/or known to have a communicable disease will be placed in the proper category of isolation based on transmission mode of the disease. A Physician, Charge Nurse or Infection Control Nurse has the authority to order and place the patient in isolation. The policy stated that signage would be universal within the acute care areas and that signs would be place on the door of the patient	E 610	To correct the issue of the facility failing to prevent the spread of infection, nursing staff will be educated on all types of isolation precautions and evaluation of the nurse's knowledge will be demonstrated through a written test. To address the infection control issue with patient #25, after the lab results are received by the lab staff, a copy will be sent to the infection control nurse and the patient's primary nurse and physician. The infection control nurse will then review the results for any MDRO's and place results on the tracking log and will also follow the guidelines for the reportable diseases. The infection control nurse will then review the inpatient or observation patient records to ensure that the patient is on the appropriate antibiotic. In the event that an outpatient result requires physician notification, the infection control nurse will do a follow-up with the physician's office to determine and ensure that the patient has received the appropriate treatment. (See attached tracking log) To correct the issue of the facility failing to prevent the spread of infection, nursing staff will be educated on all types of isolation precautions and evaluation of nurse's knowledge will be demonstrated through a written test. Lab Dept is now staffed 24/7. After culture results have been received through the electronic portal the lab technician will immediately take the paper culture results to the inpatient nurse and the Infection Control Nurse. The nurse will verify the report by placing initials with the date, time, on the report and MD notification in the electronic medical record. To ensure and monitor that culture result notification is reported the Lab will do a quality Focus Review regarding notification to the primary nurse and the Infection Control nurse this will be report through QAPI.	6/11/19 6/11/19 6/11/19 8/22/19 8/22/19

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E 610	Continued From page 22 rooms. Continued review of the policy revealed that contact precautions required gloves and handwashing, wearing of a gown in the patient's room, and to minimize transmission, patients would be placed in a private room if possible or cohorted as necessary. The use of disposable patient care equipment would be used whenever possible and all items in the patient's room should be cleaned daily. Review of the facility policy titled, "Infection Prevention Plan," approved February 2017, revealed the facility had systems in place for reporting of infection surveillance, prevention, and control information to the following: appropriate staff within the facility, federal, state and local public health authorities, Accrediting bodies including infection control related adverse event reporting, and the referring or receiving organization when a patient was transferred. Continued review of the policy revealed the Infection Prevention Chairperson and the Infection Prevention Manager/Professional were responsible for overall monitoring and evaluation of the Infection Prevention Program. The Infection Prevention Manager was responsible for employee health and safety including identifying infection prevention and control risks, monitoring of patient care activities and the implementation of applicable precautions, environmental conditions related to control of infections, safety consulting in the selection of equipment and supplies relative to control infections, and communication of infection data to administrative leadership on a routine and emergency basis. Further review of the facility policy revealed Multi-drug resistant organisms are a major facility and community safety concern including colonization of MDRO, which have the potential to proliferate, invade and infect susceptible,	E 610		

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E 610	Continued From page 23 immunocompromised individuals. Factors that may predispose the patient to acquiring MDRO's include, but are not limited to broad-spectrum antibiotics administration, and immune-deficiency. Risk reduction strategies related to reducing MDRO acquisition at the facility include but are not limited to MDRO initiatives, hand hygiene practices, and infection prevention education. Observation of Patient #25 on 05/07/19 at 11:05 AM during the initial tour of the facility revealed the patient was lying in bed with eyes closed. Review of the medical record for Patient #25 revealed the facility admitted the patient on 05/01/19 under the services of MD #5 with diagnoses of Urinary Tract Infection (UTI) with gross hematuria (blood in urine), uncontrolled Diabetes, and Hypertension. Review of the Physician's Orders dated 05/01/19 revealed an order for staff to collect a urine culture with sensitivity on 05/01/19. Further review of Patient #25's medical record revealed Physician #5 ordered the following antibiotics (medications to treat infection) to be administered: Levaquin (Levofloxacin) 250 milligrams (mg) intravenous (IV) daily and Bactrim (antibiotic combination of sulfamethoxazole and trimethoprim) 400-80 one tablet daily. Review of Patient #25 admitting physician orders revealed staff were directed to collect a urine culture with sensitivity on 05/01/19. Review of the patient's record revealed a urine culture was collected on 05/02/19 at 2:49 AM. Further review of the urine culture report revealed final results were reported on 05/05/19 at 3:35 PM, which indicated the patient had a Multidrug-Resistant organism (MDRO),	E 610		

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E 610	Continued From page 24 Extended-spectrum beta-lactamase (ESBL) in his/her urine. Review of the sensitivity report revealed the organism was resistant (would not respond) to Levaquin or Septra antibiotics. Further review of Patient #25's culture report revealed Nitrofurantoin was effective to treat the patient's infectious organism. Further review of the record revealed no evidence that the urine culture report had been reviewed or any action had been taken based on the report. Continued observation of Patient #25 on 05/07/19 at 11:05 AM revealed there was no evidence that contact precautions were in place. Further observation revealed there were two other patients on the unit, including Patient #26 was observed to be in the room across the hall from Patient #25. In addition, two nurse aides and a nurse were observed on the unit caring for Patient #25 and were not wearing protective equipment to prevent the spread of infection to staff and other residents. Interview with RN #25 on 05/07/19 at 5:00 PM revealed she was responsible for Patient #25's care on 05/07/19. The nurse stated she was not aware that the culture results were back and therefore no action was taken until the surveyor notified the nurse of the test results. Observation of Patient #25 on 05/08/19 at 1:22 PM revealed an "infection control box" on the door; however, there was no signage to indicate the type of precautions the patient required. Interview with Laboratory Technician (LT) #1 on 05/08/19 at 4:05 PM revealed she stated "all cultures" had been sent out of the facility for approximately one month, because the facility was unable to purchase the needed supplies, to	E 610		

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E 610	Continued From page 25 run the tests in-house. The LT stated she was the only lab personnel working on 05/05/19 during the day shift, 7:00 AM-7:00 PM, and she did not have access to the system the facility utilizes to obtain lab results, from labs sent out for processing from the facility. She had not been trained to track labs in the facility, and stated she was unaware of who was monitoring to ensure results were obtained of labs sent out for processing from the facility. Interview with LT #2 on 05/08/19 revealed the lab supervisor gave lab results to her (Monday-Friday) and she had been trained to fax them to the ordering physician's office. She stated she had faxed Patient #25's abnormal lab results to MD #5's office on 05/07/19; however, was not aware the patient remained in the facility, therefore direct care staff had not been notified of the abnormal lab results. She stated she had not spoken to Patient #25's physician to ensure he received the abnormal labs, because she had not been trained to do so. Interview with the Laboratory Supervisor on 05/08/19 at 1:50 PM revealed the facility was not doing cultures in the facility "because of money." She stated a payment plan had to be worked out with the supply company, because administration had not paid the balance due on the account, so needed supplies could not be obtained to run the physician ordered labs in the facility. She stated all cultures were being sent out to be resulted, and in order to receive the lab results, she had to "login to a direct link" and acknowledged weekend staff, did not have access to track labs that had been sent out, and also stated "we're not necessarily looking at lab results on the weekends." She stated she was required to track patient lab results Monday-Friday; however, had	E 610		

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E 610	Continued From page 26 not tracked send out lab results from the previous week, on 05/06/19 {Monday} as required, because she "had other things to do." Continued review of Patient #25's medical record revealed the patient had previously been admitted to the facility on 03/27/19 under services of Physician #5 with diagnoses of Osteomyelitis and Gangrene to his/her right foot, Peripheral Vascular Disease and Brittle Diabetes. Review of Patient #25's physician orders from the previous admission revealed Physician #3 (the facility surgeon) evaluated Patient #25 on 03/27/19 and ordered a wound culture, which was collected on 03/27/19. Further review of the patients record revealed the final results of Patient #25's wound culture dated 03/29/19 indicated the patient had ESBL identified in his/her wound. Review on 05/08/19 at 3:00 PM of the facility's Infection Control Tracking Log for the previous ninety days, revealed no evidence Patient #25's abnormal culture results for the MDRO, ESBL identified in the patient's wound on 03/29/19 or in his/her urine on 05/05/19 was included on the tracking log. Interview with the Infection Control (IC) Nurse on 05/07/19 at 4:30 PM revealed lab staff were required to notify her with abnormal cultures; however, they had failed to inform her that Patient #25's urine was identified to have an MDRO, ESBL on 05/05/19. She stated the patient's physician should have been notified of the abnormal lab result on 05/05/19, and staff should have ensured the patient was on the appropriate antibiotic to treat the identified infectious organism. She acknowledged the antibiotics that	E 610		

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E 610	Continued From page 27 Patient #25 was receiving in in the facility, was not the effective treatment for the patient's infectious organism. The IC nurse also stated contact precautions should have been implemented to protect staff and other patients from transmission of the infectious organism. Continued interview with the IC nurse acknowledged Patient #25 was previously diagnosed with an ESBL organism in his/her diabetic foot ulcer, during a previous hospital stay in March 2019. However, she was unsure why the patient information had not been included on the facility infection control tracking log. She also stated, because the electronic record system had not been updated due to outstanding debt, "nothing flags staff" that patients had been diagnosed with a MDRO during previous hospital stays. A post-survey interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed the physician should have been notified of Patient #25's abnormal lab results on 05/05/19. She also stated laboratory personnel should have developed an effective system, since cultures were being sent out of the facility for processing that ensured lab results were received in a timely manner. The CNO also stated patients should be placed in contact precautions when MDRO's were identified to protect staff and other patients from infectious organisms. Continued interview with the CNO revealed the facility infection control tracking log should be accurate and should include infectious organisms identified in the facility.	E 610		
{E2340}	902 KAR 20:016 4(2)(g) Section 4 Provision of Services	{E2340}		

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{E2340}	Continued From page 28 (2) Nursing service. (g) A registered nurse shall assign staff and evaluate the nursing care of each patient in accordance with the patient's need and the nursing staff available. This requirement is not met as evidenced by: Based on observation, interview, record review, review of facility policy, and review of Statements of Deficiencies and Plans of Correction for survey visits on 01/30/19 and 03/12/19, it was determined the facility failed to ensure a registered nurse supervised and evaluated the nursing care for two (2) of twelve (12) sampled patients (Patients #25 and #26). The facility failed to ensure urine culture results were monitored and addressed timely for Patient #25. The results of the patient's urine culture were available on 05/05/19 and revealed that the patient had Extended-spectrum beta-lactamase (ESBL) (a multi-drug resistant organism [MDRO]) in the urine. However, staff failed to notify the patient's physician timely of the laboratory results; subsequently, the patient did not receive timely treatment for the infection. In addition, the facility failed to take action to prevent the spread of the patient's infection to others. Further, when Patient #25 was admitted to the facility on 05/01/19, the physician progress notes revealed the patient had an ulcer present to his/her right foot, which had previously been debrided. However, review of the nursing admission assessment dated 05/01/19 revealed the nurse documented that the patient had no skin abnormalities. Further review of the record revealed nursing staff failed to identify, assess, or treat the patient's diabetic foot ulcer until 05/03/19, two days after admission.	{E2340}	To correct the issue of nursing not being aware of urine culture results, each RN will review their specific patient labs each shift and check for abnormal or pending lab results. The Infection Control nurse will perform surveillance that the nurse is checking for lab results and keep a log of compliance. To address the nursing staff failing to identify and treat the patient's diabetic foot ulcer and follow hospital nursing assessment policy, the QAPI committee has developed a new policy that will take appropriate action for nursing staff not following any policy. Upon approval of this policy, nursing staff will be in-serviced on the new policy and the actions that will be taken if policies are not followed. To address the patient #26, who was admitted on 5/7/19 at 10:30am and patient having labored breathing with no oxygen administered. The SOD stated the patient had been there for a while and the patient had not been evaluated by the nursing staff. The patient was in the facility on the inpatient medical surgical floor because this is where the facility places all outpatient (called OPD bed). The MD order states patient is an OPD. Because this patient was an OPD bed, not an Observation Patient nor an inpatient, the Initial Physical Assessment was not required, instead an OPD flowchart was required and initiated, see attached MD order. The nurse contacted the MD and a MD Telephone Order was obtained for oxygen at 11:15am. Later that evening, the patient was converted from an OPD status to an Observation status, see attached MD telephone order. After the patient was converted to observation status, the Initial Physical Assessment and Initial Interview were completed per policy guidelines at 5:48pm. Copy of Nursing Admission Documentation and Patient Admission Policy are attached	6/11/19 6/11/19

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{E2340}	Continued From page 29 In addition, on 05/07/19 at 11:05 AM, observation and interview with Patient #26 revealed the patient had labored breathing. The patient stated he/she had there "awhile" and had not been evaluated by nursing staff. At 11:15 AM, the surveyor notified nursing staff that the patient was in distress; however, the nurse did not assess or evaluate the patient, but called respiratory services to assess and treat the patient. Review of the medical record revealed that a nursing assessment was not completed for the patient until 5:48 PM (approximately 7 hours and 17 minutes after admission). The findings include: Review of a Statement of Deficiencies (SOD) issued to the facility on 01/30/19 revealed deficient practice was issued because the facility failed to have a system for consulting the Registered Dietitian (RD) when patients had feeding tubes, pressure ulcers/wounds, or Diabetes; failed to have an effective system to ensure patients received physician ordered diets; failed to have effective system for ensuring Social Services was consulted; failed to administer medications as ordered by physicians; and failed to monitor and notify a physician of a patient's urinary output as ordered. The facility submitted a Plan of Correction and alleged compliance with nursing services on 03/06/19. However, review of a SOD issued to the facility on 03/12/19, revealed facility failed to implement the POC and continued non-compliance was identified. The facility continued to fail to administer medications as prescribed by the patient's physicians. The Plan of Correction stated daily chart audits, which included ensuring	{E2340}	To correct the issue of nursing not being aware of urine culture results, each RN will review their specific patient labs each shift and check for abnormal or pending lab results. The Infection Control nurse will perform surveillance that the nurse is checking for lab results and keep a log of compliance. Copy attached of surveillance tracking sheet To correct the issue of staff failing to notify the patient's physician timely of laboratory results, resulting in the patient not receiving timely treatment and not following polices for assessments of patient # 25, the QAPI committee has developed a new policy that will take appropriate action to address the quality care concerns, specifically in this incident for nursing staff not following facility policy for MD notification. Upon approval of this policy, staff will be educated on the new policy and the actions that will be taken if polices are not followed. To correct the issue of the facility failing to take action to prevent the spread of the patient's infection to others in the facility, licensed nursing staff will be educated on all types of Isolation Precautions and evaluation of nurses' knowledge will be demonstrated through a written test. Patient # 25 had a diagnosis of a Diabetic Foot Ulcers, which according to policy does not require a photo, whereas Pressure Ulcers do require a photograph. To ensure that timely assessment and monitoring of OPD patients a quality Focus Review will be done on all OPD patients and reports through QAPI.	6/11/19 6/11/19 6/11/19 8/22/19

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{E2340}	Continued From page 30 physician orders were completed correctly and monitoring for medication administration were completed. However, review of the chart audits revealed the facility failed to identify any concerns with medication administration. 1. a. Review of the facility policy titled, "Priority List for Laboratory," last revised April 2001, revealed the policy did not address the process lab was required to follow when labs were sent out to other labs for processing. Review of the facility policy titled, "Transmission Based Isolation Precautions," approved February 2017 revealed all patients suspected of/or known to have a communicable disease will be placed in the proper category of isolation based on transmission mode of the disease. A Physician, Charge Nurse or Infection Control Nurse has the authority to order and place the patient in isolation. Signage will be universal within the acute care areas. Signs will be place on the door of the patient rooms. Continued review of the policy revealed contact precautions requires gloves and handwashing, wearing of a gown in the patient's room, patient placed in a private room if possible or cohorted as necessary, use disposable patient care equipment whenever possible and all items in the patient's room should be cleaned daily. Visitors are required to use gowns and gloves. Review of the facility policy titled, "Infection Prevention Plan," approved February 2017, revealed the facility had systems in place for the reporting of infection surveillance, prevention, and control information to the following: appropriate staff within the facility, federal, state and local public health authorities, Accrediting bodies including infection control related adverse event	{E2340}	Lab Dept is now staffed 24/7. After culture results have been received through the electronic portal the lab technician will immediately take the paper culture results immediately to the inpatient nurse and the Infection Control Nurse. The nurse will verify the report by placing initials with the date, time, on the report and MD notification in the electronic medical record. To ensure and monitor that culture result notification is reported the Lab will do a quality Focus Review regarding notification to the primary nurse and the Infection Control nurse this will be report through QAPI. To ensure patients with Diabetic Foot Ulcers will be assessed and treated per policy (see attached policy). A quality Focus Review will be done to monitor this and reported through QAPI.	8/22/19 8/22/19

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{E2340}	Continued From page 31 reporting, and the referring or receiving organization when a patient was transferred. Continued review of the policy revealed the Infection Prevention Chairperson and the Infection Prevention Manager/Professional were responsible for overall monitoring and evaluation of the Infection Prevention Program. The Infection Prevention Manager was responsible for employee health and safety including identifying infection prevention and control risks, monitoring of patient care activities and the implementation of applicable precautions, environmental conditions related to control of infections, safety consulting in the selection of equipment and supplies relative to control infections, communication of infection date, to administrative leadership on a routine and emergency basis. Further review of the facility policy revealed Multi-drug resistant organisms are a major facility and community safety concern including colonization of MDRO which have the potential to proliferate, invade and infect susceptible, immunocompromised individuals. Factors, which may predispose the patient to acquiring MDRO's, include, but are not limited to: broad spectrum antibiotics administration, and immune-deficiency. Risk reduction strategies related to reducing MDRO's acquisition at the facility include but are not limited to MDRO initiatives, hand hygiene practices, and infection prevention education. Observation of Patient #25 on 05/07/19 at 11:05 AM during the initial tour of the facility revealed the patient was lying on the bed with eyes closed. Continued observation revealed there was no evidence that contact precautions were in place. Further observation revealed there were two other patients on the unit, including Patient #26 was observed to be in the room across the hall from Patient #25.	{E2340}		

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(E2340)	Continued From page 32 Observation of Patient #25 on 05/08/19 at 1:22 PM revealed an "infection control box" on the door; however, there was no signage to indicate the type of precautions the patient required. Review of the medical record for Patient #25 revealed the patient was admitted to the facility on 05/01/19 under the services of MD #5 with diagnoses of Urinary Tract Infection (UTI) with gross hematuria (blood in urine), uncontrolled Diabetes, and Hypertension. Review of Physician's Orders dated 05/01/19 revealed an order for staff to collect a urine culture with sensitivity on 05/01/19. Further review of Patient #25's medical record revealed Physician #5 ordered the following antibiotics (treats infection) to be administered: Levaquin (Levofloxacin) 250 milligrams (mg) intravenous (IV) daily and Bactrim (antibiotic combination of sulfamethoxazole and trimethoprim) 400-80 one tablet daily. Review of the patient's record revealed a urine culture was collected on 05/02/19 at 2:49 AM. Further review of the urine culture report revealed final results were reported on 05/05/19 at 3:35 PM, which indicated the patient had a Multidrug-Resistant organism (MDRO), Extended-spectrum beta-lactamase (ESBL) in his/her urine. Review of the sensitivity report revealed the organism was resistant (would not respond) to Levaquin or Septra antibiotics. Further review of Patient #25's culture report revealed Nitrofurantoin (an antibiotic) was effective to treat the patient's infectious organism. Further review of the record revealed no evidence that the urine culture report had been reviewed or any action had been taken based on the report.	(E2340)		

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{E2340}	Continued From page 33 Interview with Registered Nurse (RN) #25 on 05/07/19 at 5:00 PM revealed she was responsible for Patient #25's care on 05/07/19. The nurse stated she was not aware that the culture results were back and therefore no action was taken to notify the patient's physician of the results or to initiate infection control precautions to prevent the spread of the patient's infection. Interview with Laboratory Technician (LT) #1 on 05/08/19 at 4:05 PM revealed she stated "all cultures" had been sent out of the facility for approximately one month, because the facility was unable to purchase the needed supplies to run the tests in the facility. The LT stated she was the only lab personnel working on 05/05/19 during the day shift, 7:00 AM-7:00 PM, and she did not have access to the system the facility utilized to obtain lab results from labs that were sent out for processing. She had not been trained to track labs in the facility, and stated she was unaware of who was monitoring to ensure results were obtained of labs sent out for processing from the facility. Interview with LT #2 on 05/08/19 at 11:25 AM revealed the lab supervisor gave lab results to her (Monday-Friday) and she had been trained to fax them to the ordering physician's office. She stated she had faxed Patient #25's abnormal lab results to MD #5's office on 05/07/19; however, was not aware the patient remained in the facility. LT #2 stated that direct care staff had not been notified of the abnormal lab results. She stated she had not spoken to Patient #25's physician to ensure he received the abnormal labs, because she had not been trained to do so. Interview with the Laboratory Supervisor on	{E2340}		

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{E2340}	Continued From page 34 05/08/19 at 1:50 PM revealed the facility was not doing cultures in the facility "because of money." She stated a payment plan had to be worked out with the supply company because administration had not paid the balance due on the account; therefore, needed supplies could not be obtained to run the physician ordered labs in the facility. She stated all cultures were being sent out to be resulted, and in order to receive the lab results, she had to "login to a direct link" and acknowledged that weekend staff did not have access to track labs that had been sent out. The Laboratory Supervisor also stated, "We're not necessarily looking at lab results on the weekends." She stated she was required to track patient lab results Monday-Friday; however, had not tracked lab results for labs that were sent out of the facility from the previous week, on 05/06/19 {Monday} as required, because she "had other things to do." Interview with the Infection Control (IC) Nurse on 05/07/19 at 4:30 PM revealed laboratory staff were required to notify her of any abnormal cultures; however, they had failed to inform her that Patient #25's urine was identified to have ESBL (an MDRO) on 05/05/19. She stated the patient's physician should have been notified of the abnormal laboratory result on 05/05/19, and staff should have ensured the patient was on the appropriate antibiotic to treat the identified infectious organism. She acknowledged the antibiotics that Patient #25 was receiving were not the effective treatment for the patient's infectious organism. The IC nurse also stated contact precautions should have been implemented to protect staff and other patients from transmission of the infectious organism. The IC nurse stated that Patient #25 was previously diagnosed with an ESBL organism in	{E2340}		

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{E2340}	Continued From page 35 his/her diabetic foot ulcer, during a previous hospital stay in March 2019. However, because the electronic record system had not been updated due to outstanding debt, "nothing flags staff" that patients had been diagnosed with an MDRO during previous hospital stays. 1.b. Review of the facility policy titled, "Skin Integrity/Pressure Ulcer," approved August 2018, revealed all patients admitted to the facility are assessed for skin integrity and the presence of a pressure ulcer or the potential for development of a pressure ulcer, to ensure that patients admitted with intact skin and without a pressure ulcer are assessed for risk factors that may potentially lead to the development of a pressure ulcer. If a pressure ulcer is present at time of admission, staffing and measurement will be done, and will be photographed and attached to the medical record. Continued review of the policy revealed all patients with a Braden score of less than 9 are considered a high risk and will be considered as having the potential for impaired skin and preventative measures will be implemented. Patients who are admitted with a pressure ulcer and those who are admitted and are identified to have potential for impaired skin integrity will have a plan of care developed addressing this area. Continued review of Patient #25's medical record revealed prior to admission to the facility on 05/01/19, MD #5 evaluated the patient in his office. MD #5 documented that the patient had burning pain and numbness to both feet and an ulcer to the right foot that had been previously debrided. The progress notes also revealed Patient #25 was status post amputation to his/her great and second toe on the left foot. However, review of Patient #25's Admission	{E2340}		

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{E2340}	Continued From page 36	{E2340}		

nursing assessment, completed by RN #7, revealed the patient was admitted to the facility at 3:56 PM on 05/01/19 and no abnormal skin integrity impairments were identified. RN #7 also documented the patients neurological and pulses were within normal limits.

Review of the nurses notes dated 05/03/19 (2 days after admission) at 11:56 AM revealed RN #4 documented that Patient #25 had an "old debridement area, open round area surrounded by extremely thick dry skin noted white/pale yellow area noted with dark area on the side, small amount of clear yellow drainage noted," to his/her right foot.

Review of the patient's record revealed no evidence the patient's diabetic foot ulcer was identified, assessed, and/or treated until 05/03/19 at 11:56 AM. Continued review of the record revealed the first measurement of the patient's diabetic ulcer was not completed until 05/04/19 (2 days after admission) at 6:00 PM by the Chief Nursing Officer (CNO). Review of the CNO's documentation revealed the patient's ulcer was "3 centimeters (cm), X 3 cms and was 0.3 cms deep with a callus present."

In addition, review of Patient #25's physician orders revealed an order was not entered to treat the patient's wound to the foot until 05/03/19 (2 days after admission) at 12:02 PM for "daily betadine dressing changes".

Further review of Patient #25's nursing documentation revealed RN #6 documented on 05/06/19 at 12:53 PM that the patient's wound had a moderate amount of serous (clear) drainage and an odor was noted. However, there was no evidence the patient's physician was

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{E2340}	Continued From page 37 notified of the foul odor to the patient's wound. Continued review of Patient #25's physician orders revealed Nurse Practitioner (NP) #1 ordered a surgical consult for the patient on 05/05/19 at 10:44 AM related to his/her diabetic ulcer. Review of Physician #3's (the facility surgeon) consultation report revealed he evaluated Patient #25 on 05/07/19 (2 days after the surgical consult was requested) and documented that the patient had an "ongoing open wound" to his/her right foot. Physician #3's documentation also revealed the patient had a history of osteomyelitis (infection of the bone), which appeared to be "settling down," and had Peripheral Vascular Disease, Diabetes, Coronary Artery Disease, Multiple Debridement, and foot surgery. Continued review of Physician #3's assessment of Patient #25 revealed there was no pulse on the dorsalis pedis (artery that carries oxygenated blood to that area of the foot) on the patient's right side, and he/she also had a 3 cm by 5 cm area of ulceration, with some cellulitis and hyperkeratotic (thickening of the outer layer of skin) skin around the patients diabetic ulcer. Interviews with RN #4 and RN #7, who provided care for Patient #25, were attempted on 05/07/19 and 05/08/19; however, no return calls were received. Interview with the Infection Control Nurse on 05/07/19 at 4:30 PM revealed if staff had observed/documented that Patient #25's wound had odorous drainage during the current hospital stay, the physician should have been notified.	{E2340}		

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(E2340)	Continued From page 38 A post-survey interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed she expected staff to complete head to toe assessments on patients when they were admitted to the facility. She also stated staff should have identified Patient #25's diabetic ulcer on admission and notified the patient's physician and obtained orders to treat the patient's ulcer. She also stated Patient #25's ulcer should have been photographed and measured as directed in the facility policy. The CNO also stated she was unsure why staff who conducted daily chart audits had not identified the concerns with Patient #25's care. She also said staff that identified odorous drainage to Patient #25's wound should have contacted the patient's physician. She also stated the laboratory department should have implemented processes to ensure labs that had been sent out of the facility for processing, and were tracked timely to ensure timely physician notification. A post-survey interview with Physician #5 on 05/13/19 at 3:35 PM revealed staff should have notified him timely of the patient's final urine culture results to ensure proper treatment. 2. Review of the facility policy titled, "Assessment and Reassessment of Patients Plan" revised February 2019 revealed Patient assessments are initiated by qualified individuals upon admission to the facility. Assessments and reassessments continued throughout the patient's stay in the facility. Continued review revealed an assessment was required to be completed on patients admitted to the facility. Each patient would have his/her needs initially assessed by a registered nurse. According to the policy, care needs are evaluated periodically and reassessed by a RN as the condition warrants. Maximum	(E2340)		

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{E2340}	Continued From page 39 time frames for the initial assessment to be completed and for the reassessment are upon admission to the medical/surgical floor. Further review of the policy revealed the RN was responsible for initiating and individualizing the Plan of Care for each patient. The RN prioritizes the identified patient needs and this included collaboration with involved disciplines when appropriate. Record review revealed the facility admitted Patient #26 on 05/07/19 at approximately 10:30 AM with diagnoses that included Asthmatic Bronchitis and Chronic Obstructive Pulmonary Disease Exacerbation. Observation of Patient #26 on 05/07/19 at 11:05 AM revealed Patient #26 was found lying in bed with the head of the bed raised. The patient was dressed in street clothing and was observed to have labored breathing. Further observation revealed Patient #26 had no Intravenous (IV) access or Oxygen in place at that time. Continued observation revealed the facility had three (3) patients admitted in the facility at the time of observation, staffed with two (2) CAN's and one (1) Registered Nurse. All nursing staff were seated at the nursing station at the time of the observation. Interview with Patient #26 on 05/07/19 at 11:05 AM revealed the patient stated, "I'm terrible." Patient #26 stated Physician #2 sent him/her over from the doctor's office for admission to the facility. Patient #26 stated "I can't breathe" and that only a "Nurse Aide" has been in the room to get a weight and someone from the kitchen had brought him/her something to eat. Continued interview revealed the patient stated "no nurse" had been in to check on the patient or to assess	{E2340}		

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{E2340}	Continued From page 40 the patient's difficulty breathing. Patient #26 stated the CAN had told him/her the nurse would be in to give him/her some medication. Interview with Registered Nurse #25 on 05/07/19 at 11:15 AM revealed that she was Patient #26's nurse for that shift. RN #25 was informed by the surveyor that Patient #26 said she was in distress and the RN said she was unaware that the patient was in distress. RN #25 contacted Respiratory Services to assess and treat Patient #26's respiratory difficulty at that time; however, observation revealed that RN #25 did not go and assess or evaluate the patient. Review of Patient #26's History and Physical dated 05/08/19 revealed Physician #2 documented the patient presented to her office as an acute walk in with increased periods of shortness of breath and dyspnea. "The respiratory difficulty is impairing [his/her] speech today. [The Patient] is having some mild respiratory distress while in the office. [The Patient] is to be admitted for further evaluation [and] treatment." Continued review revealed "The Plan" was to "Admit to medical floor, pulse doses of Medrol, IV Rocephin, IV Zithromax and DuoNeb treatments." Review of the "Initial Physical Assessment" dated 05/07/19 revealed at 10:30 AM, Nurse Aide (NA) #1 documented Patient #26's vital signs as the following: Temperature 99.2, Pulse 80, Respirations 20, Blood Pressure 131/83, Oxygen Saturation was 94 % on room air. Continued review of Patient #26's Initial Physical revealed the patient's physical assessment was conducted on 05/07/19 at 5:48 PM (seven (7) hours and seventeen (17) minutes after admission.)	{E2340}		

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{E2340}	Continued From page 41 Review of "Patient Progress Notes" dated 05/07/19 at 11:00 AM revealed an IV was placed in Patient #26's right upper arm with a #22 gauge. Review of "Patient Progress Notes" dated 05/07/19 at 11:23 AM revealed RN #25 administered Solu-Medrol 80 mg (milligrams) IV Push. Interview with the Chief Nursing Officer on 05/09/19 at 3:00 PM revealed the reason Patient #26's nursing assessment was completed seven hours after admission was because the nursing staff thought the patient was being admitted to outpatient services. The CNO offered no explanation as to why Patient #26 was placed in a bed on the Medical Surgical floor, why the physician orders were written as if the patient was staying the night, why the History and Physical indicated the patient was to be admitted to the facility, or why it was acceptable not to conduct a timely nursing assessment if the patient was admitted to outpatient services.	{E2340}		
E2920	902 KAR 20:016 4(4)(b)2m Section 4. Provision of Services (4) Laboratory services. (m) Anatomical pathology services and blood bank services shall be available in the hospital or by arrangement with other facilities. 2. Anatomical pathology. Anatomical pathology services shall be provided as indicated by the needs of the hospital, either in the hospital or under arrangement as specified in subparagraph 1.d. of this paragraph. m. The medical staff member requesting the	E2920	To correct the issue of having adequate laboratory services to meet the needs of patients #25 and #31, laboratory staff have been educated on the procedure to access an electronic file to retrieve timely receipt of lab results. Result will then be forwarded to the Infection Control nurse and the patient's primary nurse and physician. An agreement between the facility and the vendor has been reached to order supplies to perform lab test and to maintain inhouse microbiology testing. (see attached agreement)	6/11/19 6/11/19

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E2920	Continued From page 42 examination shall be notified promptly. This requirement is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined that the facility failed to provide a written description of services provided to medical staff. An interview with the Laboratory Supervisor revealed the facility did not have the supplies to conduct cultures and had been sending the specimens to an outside, contracted laboratory for approximately one month. However, the facility failed to develop a written description of the services that the contracted laboratory would provide and failed to develop a policy/procedure to ensure the facility obtained the laboratory results and acted upon the results timely. Review of Patient #25's urine culture results from the contracted laboratory dated 05/05/19 revealed the patient's urine contained bacteria that was resistant to the antibiotics prescribed for the patient. However, there was no documented evidence the facility notified the patient's physician of the test results timely. The physician ordered a blood culture for Patient #31 "stat" on 04/15/19. The facility obtained the blood specimen for the culture; however, the facility failed to ensure the blood specimen reached the contracted facility's laboratory until 04/17/19, two days later. The findings include: Review of the facility policy titled, "Priority List for Laboratory," last revised April 2001, revealed the policy did not address the process the laboratory was required to follow when lab tests were sent out to other laboratories for processing.	E2920	To correct the issue of a 'stat' blood culture on 4/15/19 and the facility failed to ensure the lab specimen reached the outside lab for 2 days. The specimen was collected on 4/15 at 830pm and the lab courier picked the specimen up the following day 4/16/19. The specimen then went to the receiving lab and they followed their procedure for blood culture intubating and reporting. On 4/17/19, we received verbal and written notification of blood culture results via fax. (see attached) To correct the issue where the facility failed to develop a written description of the services the contracted laboratory will provide. A written list of services is attached. To correct the issue of having adequate laboratory services to meet the needs of patients #25 and #31, the LT #1 and other laboratory staff have been educated on the procedure to access an electronic file to retrieve timely receipt of lab results. Results will then be forwarded to the Infection Control nurse and the patient's primary nurse and physician. An agreement between the facility and the vendor has been reached to order supplies to perform lab test and to maintain inhouse microbiology testing. (see attached agreement) The lab is now staffed 24/7 and Stat Labs will be done per policy. A quality Focus Review to monitor this will be done by the lab regarding following policy on STAT labs and will be reported through QAPI.	6/11/19 6/11/19 6/11/19 6/11/19 8/22/19

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E2920	Continued From page 43 1. Review of the Patient #25's medical record revealed Physician #5 admitted Patient #25 directly to the facility on 05/01/19 with diagnoses of Urinary Tract Infection (UTI) with gross hematuria (blood in urine), uncontrolled Diabetes, and Hypertension. Review of Patient #25 Admitting physician orders revealed staff were directed to collect a urine culture with sensitivity on 05/01/19. Further review of Patient #25's medical record revealed Physician #5 ordered the following antibiotics (treats infection) to be administered: Levaquin (Levofloxacin) 250 milligrams (mg) intravenous (IV) daily and Bactrim (antibiotic combination of sulfamethoxazole and trimethoprim) 400-80 mg one tablet daily. Further review of Patient #25's medical record revealed a urine culture was collected on 05/02/19 at 2:49 AM and the final urine culture results were reported on 05/05/19 at 3:35 PM. Review of the final results indicated the patient had a Multidrug-Resistant Organism (MDRO) called Extended-spectrum beta-lactamase (ESBL) in his/her urine. Review of the sensitivity report revealed the organism was resistant (would not respond) to Levofloxacin and sulfamethoxazole/trimethoprim antibiotic medications that the patient was receiving at the facility. There was no documented evidence the facility had notified the patient's physician that the medications that the patient was receiving would not treat the patient's infection. Interview with RN #25 on 05/07/19 at 5:05 PM revealed she had been assigned to care for Patient #25 on 05/07/19 since 7:00 AM. Even though the patient's lab results were observed in	E2920		

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E2920	Continued From page 44 the patient's medical record, the RN was not aware that the patient had laboratory results dated 05/05/19 (two days prior) that showed the patient had ESBL (an MDRO) in his/her urine. The RN acknowledged staff had not implemented contact precautions to protect staff and other patients from the MDRO and no action was taken until the facility was made aware by the surveyor. Interview with Laboratory Technician (LT) #1 on 05/08/19 at 4:05 PM revealed "all cultures" were being sent to another facility laboratory to be processed because the facility was unable to purchase the needed supplies to run the tests in-house. She stated that had been the practice for approximately one month. The LT stated she was the only staff member working in the laboratory on 05/05/19 (when Patient #25's urine culture results were available) during the day shift (7:00 AM-7:00 PM). However, the LT stated she did not have access to the computer system to obtain laboratory results from the outside facility laboratory, nor was she trained to obtain the laboratory results. LT #1 stated she was unaware who was monitoring to ensure results from the outside laboratory were obtained timely. Interview with LT #2 on 05/08/19 revealed the lab supervisor gave her laboratory results (Monday-Friday) and she faxed the results to the ordering physician's office. She stated she faxed Patient #25's abnormal lab results to MD #5's office on 05/07/19 (two days after the results were available). LT #2 stated she was not aware the patient remained an inpatient at the facility; therefore, she did not notify direct care staff of the abnormal lab results. In addition, LT #2 stated she had not spoken to Patient #25's physician to ensure he received the abnormal laboratory results because she had not been trained to do	E2920		

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E2920	Continued From page 45 SO. Interview with the Laboratory Supervisor on 05/08/19 at 1:50 PM revealed the facility was not doing any type of cultures "because of money" and the cultures were being sent to an outside facility. She stated the facility did not have supplies needed to analyze blood cultures because facility administration had not paid the balance on the account with the company that provided supplies. She stated a payment plan had to be worked out with the supply company before needed supplies could be obtained to process the laboratory testing at the facility. The Laboratory Supervisor stated to obtain the results of laboratory tests that were sent to another facility, she had to "login to a direct link"; however, only she and one other staff member had access to the account. She acknowledged staff who worked on weekends did not have access to account to obtain laboratory results and stated, "We're not necessarily looking at lab results on the weekends." She stated she was required to track patient laboratory results Monday through Friday; however, she did not have a system to review/track laboratory results from the previous week because she "had other things to do." 2. Review of Patient #31's medical record for revealed the facility admitted the patient on 04/15/19 with a diagnosis of Atrial Fibrillation with Rapid Ventricular Rate (an irregular heart rate that commonly causes poor blood flow). Review of the Physician Orders for Patient#31 revealed the physician ordered a Blood Culture on 04/15/19 at 8:24 PM STAT. Review of the Laboratory Results for Patient #31	E2920		

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E2920	Continued From page 46 revealed the facility collected a blood specimen for a blood culture on 04/15/19 at 8:30 PM. However, further review revealed the facility did not send the blood specimen to another laboratory "Out Sourced Lab" until 04/17/19 at 5:03 AM, two days after the physician's order for the laboratory was written and the blood specimen was obtained. Review of the final report revealed the patient's blood culture was positive for Gram Negative Bacilli (bacteria in the blood). Continued interview with the Laboratory Supervisor on 05/08/19 at 1:50 PM revealed Patient #31's blood specimen did not go to the "Out Sourced Lab" on 04/15/19 because the laboratory service had already picked up specimens when the blood specimen for the patient was obtained. The supervisor stated the specimen was picked up on 04/16/19, and did not arrive to the outside laboratory until 04/17/19, two days later. A post-survey interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed the laboratory department should have implemented processes to ensure laboratory tests that were sent out of the facility for processing were tracked to ensure timely physician notification.	E2920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180021	A. BUILDING _____ B. WING _____	R 03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(A 043)	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on interview, record review, and review of Governing Body Meeting minutes, facility audits, Daily Operating Budget, and the Plan of Correction the facility submitted for the Statement of Deficiencies dated 01/30/19, it was determined the facility failed to have an effective governing body that was responsible for the conduct of the facility. During a complaint visit concluded on 01/30/19, Immediate Jeopardy was identified in the areas of Governing Body, Patient Rights, Quality Assurance and Performance Improvement (QAPI), Nursing Services, Pharmaceutical Services, Discharge Planning, Surgical Services, and Emergency Services. The facility submitted a Plan of Correction which alleged compliance/correction of the above noncompliance on 03/06/19. However, the facility failed to implement the plan of correction related to the Chief Executive Officer (CEO), Budget, QAPI, and Nursing Services. The CEO failed to ensure staff had completed the trainings included on the above plan and the CEO failed to ensure audits were completed per the hospital's plan of correction. The facility failed to ensure the annual operating budget was prepared according to generally accepted accounting principles. The budget did not include	(A 043)	The Governing Board appointed a new CEO who is providing oversight to ensure quality care is being provided. Presently the PI committee is meeting weekly at which time performance indicator's and audit findings are being reported. The CEO attends the weekly PI meetings where nursing chart audit results; medication errors, and quality indicators are reported along with plans of corrections as needed. Also reported are all training/in-services offered and includes methods of training as well as evaluation results and percentage of employees trained. A Governing Board member is on the PI committee as well as a physician who is the Chairperson. The committee reports are sent to the Governing Board and MEC. The budget was approved by the Governing Board on 2/26/19. An addendum will be added to include repayment of outstanding debt which includes all vendor debt and the repayment schedule for tax liabilities. The Board has approved agreements with taxing authorities to ensure liabilities are met see board minutes. The Chart Audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day. Nursing Administration will maintain a nursing verbal counseling log to include all medication Counselling sessions. Medication errors will be reported though a paper report to the Risk Management committee to monitor patterns or trends.	4/14/19 4/14/19 4/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 4/2/19

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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{A 043}	Continued From page 1 repayment of outstanding debt and failed to fully disclose the hospital's monetary situation. The facility failed to pay employee taxes (federal, state, and city) for the 4th quarter of 2018 and the facility was still unable to meet payroll for all staff on 03/01/19. Staff were not all paid until 03/08/19 (a week after due). In addition, the hospital was still behind on repaying their debt to the pharmacy distributor and as of 03/12/19, orders for medications are filled on a case by case basis. The facility failed to ensure that performance indicators and audits were collected and reviewed per the Quality Improvement Plan and per the Plan of Correction for the Statement of Deficiencies issued on 01/30/19. The Plan of Correction for the Statement of Deficiencies dated 01/30/19 included the completion of daily chart audits which included monitoring medication administration and completion of physician orders. However, the audits were not completed per the plan and did not identify concerns with omitted/missed doses of medications involving Patient #16 and Patient #13. The facility failed to ensure a registered nurse supervised and evaluated the nursing care for two sampled patients (Patients #13 and #16) related to medication administration and failed to ensure medications were transcribed correctly for Patient #14. (Refer to A0057, A0073, A0263, A0273, A0385, and A0395.)	{A 043}		
{A 057}	CHIEF EXECUTIVE OFFICER CFR(s): 482.12(b) The governing body must appoint a chief	{A 057}	The Governing Board appointed a CEO 2/19/19. The CEO will provide monthly and as needed reports to the Governing Board which will list outstanding debt including pharmacy supplier payments, taxes, and employee payroll.	4/14/19

M K Cal

CEO 4/2/19

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{A 057}	Continued From page 2 executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Based on interview, record review, and review of Governing Body Meeting minutes, facility audits, Daily Operating Budget, and the Plan of Correction the facility submitted for the statement of deficiencies issued on 01/30/19, it was determined that the facility failed to ensure the Chief Executive Officer (CEO) was responsible for managing the hospital budget and implementing the Plan of Correction. The CEO failed to ensure the operating budget included current revenues and debts. In addition, the CEO failed to ensure staff training and audits were completed in accordance with the facility's Plan of Correction. The findings include: Review of the Governing Body Meeting minutes dated 02/22/19 revealed the CEO was approved to serve as the Interim CEO effective 02/27/19. 1. The Pharmacy Supplier who supplied the hospital with medication was contacted during the revisit and information from the pharmacy was received on 03/13/19 and 03/14/19. Review of information received via email on 03/13/19 from the facility's Pharmacy Supplier revealed the facility was behind approximately $115,000 on their payment plan and another $27,000 was due on 03/20/19. Additional information received on 03/14/19 revealed the company that owns the hospital had paid approximately $89,000 toward their past due amount in order to receive shipments. However, continued to owe the Pharmacy Supplier a total of $377,000. Per	{A 057}	The budget was approved by the Governing Board on 2/26/19. An addendum will be added to include repayment of outstanding debt which includes all vendor debt and the repayment schedule for tax liabilities. The Board has approved agreements with taxing authorities to ensure liabilities are met see board minutes. Staff training/in-services are being conducted as needed based on ongoing nursing audits. This training is done in classroom, one on one or small group meetings. Staff understanding of training is measured. A list of training/in-services as well as methods, attendance, and evaluation of understanding is reported to the PI Committee of which the CEO, a Board Member and Medical Staff Member attend. The Chart Audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day. Nursing Administration will maintain a nursing verbal counseling log to include all medication Counselling sessions. Medication errors will be reported though a paper report to the Risk Management committee to monitor patterns or trends.	4/14/19 4/14/19 4/14/19

M. K [illegible] CEO 4/2/19

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(A 057)	Continued From page 3 information received on 03/14/19 from the supplying pharmacy, the decision whether to provide medications to the facility is determined each time an order is placed. Review of the daily operating budget revealed the revenue and expenses were listed on a monthly basis for the current fiscal year July 2018 through June 2019. However, the daily budget did not include payments for outstanding debts (loans, debt owed to the Pharmacy Supplier). In addition, the revenue section included a Disproportionate Share Hospital (DSH) revenue of $99,000 per month from January 2019 through June 2019. Interview with the Chief Executive Officer (CEO) on 03/07/19 at 11:27 AM, 2:20 PM, and 4:12 PM, on 03/08/19 at 2:10 PM, and on 03/12/19 at 2:02 PM revealed the Governing Body Board had met on 02/22/19 and appointed him as CEO. The CEO stated he and the owner developed the budget; however, the CEO stated the repayment of debt was not included in the budget. Per the CEO, even though the facility was still in debt to the contracted pharmacy and was making payments of $28,000 per month to repay the debt, the debt was not included in the budget. Further interview with the CEO revealed employee taxes (Federal, State, and City) for the fourth quarter (October - December) of 2018 had not been paid. The CEO stated the taxes had been withheld from the employees' paychecks, but had not yet been paid to the federal, state, or city governments. In addition, the facility had not paid employee state taxes for February 2019. Continued interview with the CEO revealed the hospital did not have the funds to pay employees on 03/01/19, but did not know until late afternoon	(A 057)	In the case of Patient #16 the patient had been discharged and IV access was removed before the 11:00 o'clock dose of IV Levaquin was due. The pharmacist was not notified timely through the EHR that the patient had been discharged. The omission of patient #16's Levaquin was not identified because the pharmacy was looking at the discharge date and not the discharge time. The pharmacists have been verbally educated on the necessity of looking at the discharge time as well as the date in order to discover all medication errors. The director of pharmacy has counseled the nursing staff to discharge patients from the EHR system as soon as the patient is discharged. Licensed nursing staff will be counseled by nurse administration to not remove any IV access until patient is ready to leave the facility. Patient # 13 was on a fluid restriction and no documentation related how nursing staff was to implement the fluid restriction plan. In March 2019, a policy and procedure were developed on Fluid Restriction. Nursing staff will be in-serviced by nursing administration on the Fluid Restriction Policy which includes placement of the fluid restriction plan on the Medact which is the electronic Kardex for nursing orders. The Registered Dietician will provide further education on fluid restriction diet to nursing staff. Evaluation of knowledge will be demonstrated through a written test. RN #5 was identified as being the same nurse involved in the med errors on Patient #14 and #16. This RN #5 received 1:1 counselling and re-education on the Physician Orders policy and Medication Administration policy by ACNO. Evaluation of the nurse's knowledge will be demonstrated through a written test.	4/14/19 4/14/19 4/14/19 4/14/19 4/14/19

M. K Cal

CEO 4/2/19

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(A 057)	Continued From page 4 on 03/01/19 that funds were not available. Per the CEO, direct care staff were not paid until 03/07/19 and administrative staff were paid at 2:00 PM on 03/08/19. The CEO stated funds for the 03/15/19 payroll were not available as of 03/12/19. Continued interview with the CEO revealed when calculating the budget for January 2019 through June 2019, he included $99,000 of revenue per month that was expected from DSH Payments. However, the expected DSH payment would not be received until November 2019 (which is not in the same fiscal year). 2. Review of the Plan of Correction (POC) submitted for the Statement of Deficiencies (SOD) dated 01/30/19 revealed the CEO was responsible for ensuring staff were trained/in-serviced. Interview with the Assistant Chief Nursing Officer (ACNO) on 03/08/19 at 2:25 PM revealed, "We tried to do as much of the training/in-service in person with the nursing staff; however, some of the policies were given to the staff and the staff were expected to read the policy and sign the in-service roster. We did not ensure the staff had completed the in-services." Interview with Licensed Practical Nurse (LPN) #1 on 03/08/19 at 2:30 PM and with Registered Nurse (RN) #2 on 03/12/19 at 1:40 PM confirmed some of the recent in-service training (included on plan of correction) consisted of a policy being left for staff to read and signing a training roster. LPN #1 also stated there was a book at the nurses' station with the policies.	(A 057)	Licensed nursing staff will be re-educated on Medication Administration Policy and Physician Orders Policy by Nursing Leadership. Evaluation of the nurse's knowledge will be demonstrated through a written test.	4/14/19

M. [illegible]

CEO 4/2/19

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(A 057)	Continued From page 5 3. Review of the Plan of Correction (POC) submitted for the Statement of Deficiencies (SOD) dated 01/30/19 revealed the CEO would be responsible to ensure adequate resources were available, allow staff sufficient time to participate in Quality Assurance Performance Improvement (QAPI) activities, and institute appropriate information systems for collection and analyzing data. The plan further stated the CEO would report any and all findings to the governing body. 3. A. Review of Patient #16's medical record revealed the facility admitted the patient on 03/02/19 with a diagnosis of Acute Pyelonephritis. Review of Patient #16's physician orders dated 03/03/19, included an order for Levaquin (antibiotics) 750 milligrams (mg) intravenous (IV) to be administered daily. Review of Patient #16's physician progress notes dated 03/05/19, revealed the physician documented the patient's discharge home would be planned the following morning (03/06/19) and to continue the patient's IV antibiotics. However, review of Patient #16's Medication Administration Record (MAR) revealed staff failed to administer Patient #16's IV antibiotics on 03/06/19, as prescribed. Interview with Registered Nurse (RN) #5 on 03/07/19 at 10:45 AM revealed she had not administered Patient #16's IV Antibiotic (Levaquin) as prescribed by the physician on 03/06/19. Interview with the Assistant Chief Nursing Officer (ACNO) on 03/07/19 at 3:25 PM revealed she	(A 057)		

M. K Cu CCO 4/2/19

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(A 057)	Continued From page 6 had conducted a chart audit of Patient #16's medical record on 03/06/19, but had not identified the medication error. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she was monitoring daily for medication errors in the facility, and when medications were omitted, it was a medication error. Per the Pharmacist, she had not identified that Patient #16 had not received the IV Antibiotic Levaquin as prescribed on 03/06/19. 3. B. Review of Patient #13's medical record revealed the hospital admitted the patient on 03/08/19 with a diagnosis of Congestive Heart Failure (CHF). The physician's orders dated 03/08/19 included an order for Lasix 40 milligrams (mg) IV twice per day. In addition, on 03/09/18, an order for a 2000-milliliter (ml) fluid restriction was received. However, further review of the medical record revealed no documentation that the 6:00 PM scheduled dose of Lasix was administered and no documentation related to how nursing staff planned to implement the patient's 2000 ml fluid restriction. Review of the Plan of Correction for the 01/30/19 Statement of Deficiencies revealed daily chart audits would be completed. Review of the chart audit tool revealed the hospital was monitoring to ensure physician orders were completed correctly; medications were administered timely, etc. Review of the tool for 03/08/19 through 03/11/19 revealed the hospital had not identified that a dose of Lasix was not documented as given on 03/09/19 or that there was not plan for implementing the Patient #13's fluid restriction.	(A 057)		

M. K [illegible]

CEO 4/1/19

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{A 057}	Continued From page 7 Review of the daily audit tool (Medical-Surgical Chart Audit Tool) dated 03/08/19 through 03/11/19 revealed there four (4) to six (6) patients on the medical-surgical unit between 03/08/19 and 03/11/19. The tool included a category to audit timely administration of medication, medication omissions, etc. On 03/09/19, the audit tool failed to include a review of Patient #13. Review of 03/10/19 and 03/11/19 audit sheets revealed staff had reviewed Patient #13's medical record, but had not identified any problems with medication administration or that the ordered Lasix was not documented as administered on 03/09/19. Interview with Assistant Director of Nursing (ADON) and RN #8 on 03/12/19 at 8:45 AM revealed they did the Medical-Surgical Chart Audit for 03/09/19. The ADON stated she completed the audit for 03/09/19 at approximately 10:00 AM. She stated she reviewed documentation that had been completed since 12:00 AM, and stated the next day the same time frame would be reviewed. The ADON stated she saw now she was doing the audit wrong and should be looking at a 24-hour period. The ADON stated they did not identify that Patient #13's Lasix was not documented as given for the 6:00 PM dose on 03/09/19. Interview with Nurse Aide #1 on 03/11/19 at 4:40 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home. Per the Nurse Aide, she was not aware Patient #13 was on fluid restrictions. Interview with RN #7 on 03/11/19 at 4:57 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home	{A 057}		

M. K Cal CEO 4/2/19

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{A 057}	Continued From page 8 (mid-morning, 03/11/19). The RN stated the patient was on a 2000 ml fluid restriction and pointed out that the restriction was documented on the facility Med Act (Kardex used for nursing orders); however, there was no specific plan as to how the fluid restriction would be implemented. The intake record for that morning showed the patient had consumed 960 ml by 8:00 AM. Interview with the Assistant Director of Nursing (ADON) and RN #8 on 03/12/19 at 8:45 AM revealed she and RN #8 had completed the charts audits for 03/09/18. The ADON reviewed Patient #13's record and could not find a plan for implementing the fluid restriction. The ADON stated the lack of planning for the fluid restriction had not being identified on the chart audit. Interview with the CEO on 03/08/19 at 10:00 AM revealed he attended the weekly QAPI Meetings and that he was monitoring staff training. The CEO stated he had "learned today" (after identified by the surveyors) that some staff had not received training. The CEO stated he was not aware that the staff training consisted of staff reading a policy and signing an in-service record. The CEO said he thought the training would be 1:1 or in a group setting with some sort of testing after the training. The CEO further stated he had not been notified of any concerns with the chart audits and was not aware of any medication errors or omissions.	{A 057}		
{A 073}	INSTITUTIONAL PLAN AND BUDGET CFR(s): 482.12(d) The institution must have an overall institutional plan that meets the following conditions: (1) The plan must include an annual operating	{A 073}		

M. K Cirl CEO 4/2/19

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(A 073)	Continued From page 9 budget that is prepared according to generally accepted accounting principles. (2) The budget must include all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense. (3) The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph (d)(2) of this section is applicable. (4) The plan must include and identify in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following: (i) Acquisition of land; (ii) Improvement of land, buildings, and equipment; or (iii) The replacement, modernization, and expansion of buildings and equipment. This STANDARD is not met as evidenced by: Based on interview, record review, policy review, review of accounting websites, and review of the facility budget, it was determined that the facility failed to ensure the annual operating budget was prepared according to generally accepted accounting principles. Review of the facility's budget revealed the facility failed to ensure the budget included repayment of outstanding debt and failed to fully disclose the hospital's monetary situation. The facility failed to pay employee taxes (federal, state, and city) for the 4th quarter of 2018; employee taxes for February 2019; and owed $377,000 to the Pharmacy Supplier. However, the facility failed to include the debt in	(A 073)	The budget was approved by the Governing Board on 2/26/19. An addendum will be added to include repayment of outstanding debt which includes all vendor debt and the repayment schedule for tax liabilities. The Board has approved agreements with taxing authorities to ensure liabilities are met see board minutes.	4/14/19

CEO 4/2/19

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{A 073}	Continued From page 10	{A 073}		

their budget. Further, as of 03/12/19, funds were not available to meet payroll due on 03/15/19. In addition, the budget included revenue ($99,000 per month from January through June 2019) for income that will not be received until November 2019 (the next fiscal year).

The findings include:

Review of the policy, "Strategic Plan, Operating Budget, and Three (3) Year Capital Expense Budget," dated February 2019, revealed the Hospital Administration will initiate, develop, and complete an annual strategic plan, operation budget, and three-year capital expense budget that will be forwarded to the Medical Executive Committee and Board of Directors for approval.

Per the web site, investor.gov (US Securities and Exchange Commission), Generally Accepted Accounting Principles (GAAP) are accounting standards, conventions, and rules. It is what companies use to measure their financial results. These results include net income as well as how companies record assets and liabilities. In the US, the SEC has the authority to establish GAAP. However, the SEC has historically allowed the private sector to establish the guidance.

According to accounting.com, "Generally Accepted Accounting Principles" (GAAP) include "Principle of periodicity: Reporting of revenues is divided by standard accounting time periods, such as fiscal quarters or fiscal years and Principle of materiality: Financial reports fully disclose the organization's monetary situation."

Review of the daily operating budget revealed the revenue and expenses were listed on a monthly

M. K. C.

CEO 4/2/19

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{A 073}	Continued From page 11 basis for the current fiscal year July 2018 through June 2019. Further review revealed the budget did not include payments for outstanding debts. In addition, the revenue section included a Disproportionate Share Hospital (DSH) revenue of $99,000 per month from January 2019 through June 2019. The Pharmacy Supplier, who supplied the hospital with medication was contacted during the revisit and information from the pharmacy was received on 03/13/19 and 03/14/19. Review of information received via email on 03/13/19 from the facility's Pharmacy Supplier revealed the facility was behind approximately $115,000 on their payment plan and another $27,000 was due on 03/20/19. Additional information received on 03/14/19 revealed the company that owns the hospital had paid approximately $89,000 toward their past due amount in order to receive shipments. However, the hospital continued to owe the Pharmacy Supplier a total of $377,000. Per information received on 03/14/19 from the supplying pharmacy, the decision whether to provide medications to the facility is determined each time an order is placed. Interview with the Chief Executive Officer (CEO) on 03/07/19 at 11:27 AM, 2:20 PM, and 4:12 PM, on 03/08/19 at 2:10 PM, and on 03/12/19 at 2:02 PM revealed the Governing Body Board had met on 02/22/19 and appointed him as CEO. The CEO stated he and the owner developed the budget; however, the CEO stated the repayment of debt was not included in the budget. Per the CEO, even though the facility was still in debt to the contracted pharmacy and was making payments of $28,000 per month to repay the debt, the debt was not included in budget.	{A 073}		

M. K [illegible]

CEO 4/1/19

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(A 073)	Continued From page 12 Further interview with the CEO revealed employee taxes (Federal, State, and City) for the fourth quarter (October - December) of 2018 had not been paid. The CEO stated the taxes had been withheld from the employees' paychecks, but had not yet been paid to the federal, state, or city governments. In addition, the facility had not paid employee state taxes for February 2019. Continued interview with the CEO revealed the hospital did not have the funds to pay employees on 03/01/19, but did not know until late afternoon on 03/01/19 that funds were not available. Per the CEO, direct care staff were not paid until 03/07/19 and administrative staff were paid at 2:00 PM on 03/08/19. The CEO stated funds for the 03/15/19 payroll were not available as of 03/12/19. Continued interview with the CEO revealed when calculating the budget for January 2019 through June 2019, he included $99,000 of revenue per month that was expected from DSH Payments. However, the expected DSH payment would not be received until November 2019 (which is not in the same fiscal year).	(A 073)		
(A 263)	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or	(A 263)	The Chart Audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day. Medication errors will be reported though a paper report to the Risk Management committee to monitor patterns or trends.	4/14/19

M. K Eck

CEO 4/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 263}	Continued From page 13 arrangement), and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview, record review, audit review, review of the Quality Improvement Plan, and review of the Plan of Correction for the Statement of Deficiencies issued on 01/30/19, it was determined the hospital failed to develop and implement an ongoing, hospital-wide, date-driven quality assessment and performance improvement program. The hospital failed to ensure that performance indicators and audits were collected and reviewed per the Quality Improvement Plan and per the Plan of Correction for the Statement of Deficiencies issued on 01/30/19. The Plan of Correction for the Statement of Deficiencies dated 01/30/19 included the completion of daily chart audits which included monitoring medication administration and completion of physician orders. The plan of correction completion date or correction date was listed as 03/06/19. However, the audits were not completed per the plan and did not identify concerns with omitted/missed doses of medications involving Patient #16 and Patient #13. Refer to tags A273, A385, and A395.	{A 263}		
{A 273}	DATA COLLECTION & ANALYSIS CFR(s): 482.21(a), (b)(1), (b)(2)(i), (b)(3) (a) Program Scope	{A 273}		

M. [illegible]

CEO 4/1/19

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(A 273)	Continued From page 14 (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on interview, record review, audit review, and review of the Quality Improvement Plan, the hospital failed to ensure that performance indicators and audits were collected and reviewed per the Quality Improvement Plan and per the Plan of Correction for the Statement of Deficiencies issued on 01/30/19. The Plan of Correction for the Statement of Deficiencies dated 01/30/19 revealed daily chart audits would be completed which included monitoring medication administration and completion of physician orders. The Plan of Correction	(A 273)	The Chart Audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day. Medication errors will be reported though a paper report to the Risk Management committee to monitor patterns or trends. An annual meeting calendar has been developed to ensure timely meeting of the medical staff committees. These committees include: MEC, PI, Utilization Review/Risk Management, Blood Utilization/Infection Control/Surgery and P&T/ Dietary. Also, those department managers not members of the PI Committee will be scheduled on a rotating basis to attend and give their quality reports. All Medical Staff Committee reports will be given to the PI Committee, MEC, and Governing Board. The facility process frame work is the Plan, Do, Study, Act (PDSA). The program looks at high risk, high volume, problem prone processes. Also, Utilization Review/ Risk Management Committees meet every two months. Surgery/ Blood Utilization/ Infection Control, and P&T / Dietary/ Health Information Management will all meet quarterly. Data on Organ procurement, Mortality Review, Incident reports, Restraint and Seclusion use are collected concurrently and reported at respective committees.	4/14/19 4/14/19 4/14/19

M. C [illegible]

CEO 4/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(A 273)	Continued From page 15	(A 273)		

completion date or correction date was listed as 03/06/19. However, the audits were not completed per the plan and failed to identify concerns with omitted/missed doses of medications involving Patient #16 and Patient #13. The nursing audits also failed to identify a transcription error with Patient #14. The Plan of Correction also stated a review of all Performance Indicators would be conducted in the weekly Quality Assurance Performance Improvement (QAPI) meeting; however, only the performance indicators included in the Plan of Correction were reviewed in these meetings. In addition, the hospital's revised Quality Improvement Plan included scope of the program and areas to be reviewed in the program; however, the facility failed to obtain data for several of these areas to include: Mortality Review, Organ Procurement, Data Management, Measures related to Regulatory Requirements, Moderate/Deep Sedation, and Anesthesia Adverse Events, etc.

The findings include:

Review of the hospital's 2019 Quality Improvement Plan signed 03/05/19 revealed the areas included in the scope of the program were high risk, high volume or problem prone processes; infection control; restraint and seclusion use; mortality review; blood and blood product use; organ procurement; utilization review; data management; measures related to regulatory requirements, etc. The plan also listed the committee members, the process improvement framework, and reporting format.

Review of the Plan of Correction (POC) for the Statement of Deficiencies (SOD) dated 01/30/19

M. K Cal

CEO 4/4/19

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{A 273}	Continued From page 16 revealed "Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily nursing staff to ensure compliance. Chart audit tools are collected by the ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken." Interview with the Medical Director on 03/08/19 at 2:25 PM revealed she was also appointed as the hospital Quality Medical Director in late February 2019. The Quality Medical Director stated she had attended the weekly Quality Improvement (QI) meeting on 03/04/19, but had not discussed the new QI process with the Chief Nursing Officer (CNO), who is the acting Quality Director. Interview with the Assistance Chief Nursing Officer (ACNO) on 03/07/19 at 3:25 PM and with the CNO on 03/07/19 at 4:00 PM revealed the ACNO, management staff, and direct care nurses were collecting data for the chart audits as required by the POC for the 01/30/19 Statement of Deficiencies. The ACNO and CNO stated that sometimes the nurse who cared for the patient that day would also collect the data. 1. Review of Patient #16's medical record revealed the facility admitted the patient on 03/02/19 with a diagnosis of Acute Pyelonephritis. Review of Patient #16's physicians orders dated 03/03/19, revealed the physician prescribed Levaquin (antibiotic) 750 milligrams (mg) intravenous (IV) to be administered daily. Review of Patient #16's physician progress notes	{A 273}		

M. K. C.

CEO 4/1/19

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(A 273)	Continued From page 17 dated 03/05/19, revealed the physician documented the patient's discharge home would be planned the following morning (03/06/19) and to continue the patients IV antibiotics. However, review of Patient #16's Medication Administration Record (MAR) revealed staff failed to administer Patient #16's IV antibiotics on 03/06/19, as prescribed. Interview with the Assistant Chief Nursing Officer (ACNO) on 03/07/19 at 3:25 PM revealed she had conducted a chart audit of Patient #16's medical record on 03/06/19, but did not identify the medication error. She stated she was unsure why the medication error had not been identified. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she was monitoring daily for medication errors in the facility, but had not identified that the Levaquin had not been administered as ordered to Patient #16. The Pharmacist stated "we should have caught that," and was unsure why the medication error had not been identified. 2. Review of Patient #13's medical record revealed the hospital admitted the patient on 03/08/19 with a diagnosis of Congestive Heart Failure (CHF). The physician's orders dated 03/08/19 revealed the patient required Lasix (diuretic) 40 milligrams (mg) IV twice per day. In addition, on 03/09/18, the physician ordered a 2000-milliliter (ml) fluid restriction. Further review of Patient #13's medical record revealed no documentation that the 6:00 PM scheduled dose of Lasix was administered to the patient and no documentation related to how nursing staff planned to implement the patient's	(A 273)		

M. K C M CEO 4/2/19

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{A 273}	Continued From page 18 2000 ml fluid restriction. Review of the Plan of Correction for the 01/30/19 Statement of Deficiencies revealed daily chart audits would be completed. Review of the chart audit tool revealed the hospital was monitoring to ensure physician orders were completed correctly; medications were administered timely, etc. Review of the tool for 03/08/19 through 03/11/19 revealed the hospital had not identified that a dose of Lasix was not documented as given on 03/09/19 or that there was not a plan for implementing the Patient #13's fluid restriction. Review of the daily audit tool (Medical-Surgical Chart Audit Tool) dated 03/08/19 through 03/11/19 revealed there were four (4) to six (6) patients on the medical-surgical unit between 03/08/19 and 03/11/19. The tool included a category to monitor timely administration of medication, medication omissions, etc. Further review of the audit tool dated 03/09/19 revealed no documented evidence the facility audited Patient #13's medical record. Review of 03/10/19 and 03/11/19 audit sheets revealed staff had reviewed Patient #13's medical record, but had not identified any problems with medication administration or that the physician ordered Lasix was not documented as administered on 03/09/19. Interview with Assistant Director of Nursing (ACNO) and RN #8 on 03/12/19 at 8:45 AM revealed they conducted the Medical-Surgical Chart Audit for 03/09/19. The ACNO stated she completed the 03/09/19 audit at approximately 10:00 AM and reviewed documentation since 12:00 AM that morning. The ACNO stated the next day, the same time frame would be reviewed. The ACNO stated she saw now she	{A 273}		

M. K [illegible]

CEO 4/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 273}	Continued From page 19 was doing the audit incorrectly and should be looking at a 24-hour period. The ACNO stated they did not identify that Patient #13's 6:00 PM dose of Lasix on 03/09/19 was not documented as given. Interview with Nurse Aide #1 on 03/11/19 at 4:40 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home. Per the Nurse Aide, she was not aware Patient #13 was on fluid restrictions. Interview with RN #7 on 03/11/19 at 4:57 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home (mid-morning, 03/11/19). The RN stated she was aware the patient was on a 2000 ml fluid restriction and pointed out the restriction on the facility Med Act (Kardex used for nursing orders); however, there was no specific plan on the Kardex as to how the fluid restriction would be implemented. Review of Patient #13's intake record for 03/11/19 revealed the patient had consumed 960 ml of fluids by 8:00 AM. Interview with the Assistant Director of Nursing (ACNO) and RN #8 on 03/12/19 at 8:45 AM revealed she and RN #8 had completed the charts audits for 03/09/18. The ACNO reviewed Patient #13's record and could not find a plan for implementing the fluid restriction. The ACNO stated the lack of planning for the fluid restriction had not being identified on the chart audit. 3. Review of Patient #14's medical record revealed the patient was admitted to the facility on 03/06/19 with a diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) and Anemia.	{A 273}		

M.L.C.

CGO 4/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 273}	Continued From page 20 Review of Patient #14's physician orders revealed Physician #4 ordered Robitussin (Dextromethorphan) DM (treats cough and congestion) one (1) or two (2) teaspoons (tsp) to be administered by mouth four times daily, as needed. Review of the Medication Error Tracking Form dated 03/07/19 revealed pharmacy staff identified on 03/07/19 at 5:21 PM that RN #5 had entered Tussionex (treats coughs and common cold and allergies) into the facility medication administration system, instead of entering the medication (Robitussin) that was ordered by the physician. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she had identified a transcription error on 03/07/19, where RN #5 had transcribed a medication ordered incorrectly for Patient #14. She stated the error was identified, and the patient never received the wrong medication. The Pharmacist stated she notified the Chief Nursing Officer (CNO) of the error, when it was identified on 03/07/19. Interview with the CNO who was also the Quality Director on 03/08/19 at 8:55 AM revealed the last weekly QI meeting was on 03/04/19. The CNO stated not all Performance Improvement indicators were reviewed. Per the CNO, only the indicators/audits in the Plan of Correction for the 01/30/19 Statement of Deficiencies were reviewed in the weekly meeting. However, the CNO stated the audit tool did not include change in patient condition/pressure sore monitoring as was directed on the plan of correction.	{A 273}		

M.K.C. CEO 4/2/19

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(A273)	Continued From page 21 Refer to A385 and A395.	(A273)		
(A385)	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on interview, record review, policy review, review of facility audits, and review of the Plan of Correction for the Statement of Deficiencies dated 01/30/19, it was determined that the facility failed to ensure nursing services were furnished or supervised by a registered nurse. Record review and interview with staff revealed the facility failed to administer Patient #16's intravenous (IV) Levaquin (antibiotic medication to treat infections) as prescribed by the physician on 03/06/19. Patient #16's physician was not notified of the medication omission error by RN #5, as required on 03/06/19. Further, record review and interview revealed nursing staff (RN#5) also incorrectly transcribed a physician's ordered cough medication to Patient #14's Medication Administration Record (MAR). Although, the incorrect medication was not administered, interviews revealed nursing administration had not identified the error with Patient #14 and #16 involved the same nurse. Review of Patient #13's medical record revealed the patient had physician's orders dated 03/08/19 to received IV (intravenous) Lasix (diuretic) twice per day; however, there was no documentation	(A385)	In the case of Patient #16 the patient had been discharged and IV access was removed before the 11:00 o'clock dose of IV Levaquin was due. The pharmacist was not notified timely through the EHR that the patient had been discharged. The omission of patient #16's Levaquin was not discovered because the pharmacy was looking at the discharge date and not the discharge time. The pharmacists have been verbally educated on the necessity of looking at the discharge time as well as the date in order to discover all medication errors. The director of pharmacy has counseled the nursing staff to discharge patients from the EHR systems as soon as the patient is discharged. Licensed nursing staff will be counseled by ACNO or when ACNO not available by nurse administration to not remove any IV access until patient is ready to leave the facility.	4/14/19
			Patient #14 and #16's med error was by the same RN. The RN received 1:1 counseling and reeducation on the physician orders policy and Medication Administration policy by the ACNO evaluation of the nurse's knowledge was demonstrated through a written test. Also, all licensed nursing staff are receiving education on Medication Administration policy and Physician Orders policy with a written test to demonstrate knowledge. Medication errors are reported to Risk Management Committee to monitor patterns or trends.	4/14/19
			Patient #13 had order for a fluid restriction but had no plan to carry out the order. Also, Patient #13 missed a dose of Lasix. The nurse aides will be educated on the fluid restriction policy by Nurse Administration. The primary nurse of the patient will be responsible for reviewing the Medact the electronic Kardex for nursing orders and ensuring that the nurse aides are knowledgeable of the patient's diet order including fluid restrictions from the patient's nurse each shift. A sign will be posted above the patient's bed for further clarification for all dietary restrictions. Nursing staff and the Dietary Manager will be educated by Nursing Administration on the Fluid Restriction Policy and how to implement a plan for fluid restrictions. The nursing staff will be given written amount of fluid on each meal tray when trays are delivered.	4/14/19

Mr. K Cal CEO 4/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180021	A. BUILDING _____ B. WING _____	R 03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN KY MEDICAL CENTER	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

(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) COMPLETION DATE
{A 385}	Continued From page 22 that the patient received the 6:00 PM dose of Lasix on 03/09/19. Patient #13 also had a physician order for 2000-milliliter fluid restriction; however, interviews revealed nursing staff failed to develop a plan to implement the fluid restriction. Review of medical records and facility audits revealed the facility failed to implement the Plan of Correction for the Statement of Deficiencies dated 01/30/19 in which immediate jeopardy for Nursing Services was identified. The Plan of Correction stated daily chart audits which included ensuring physician orders were completed correctly and monitoring for medication administration were completed. However, review of the chart audit revealed the facility failed to identify any concern with Patient #13's Lasix administration on 03/09/19, the transcription of Patient #14's cough medication, or that Patient #16 did not receive IV Levaquin as prescribed on 03/06/19. Refer to A395, A263, and A273.	{A 385}	Nursing staff and the Dietary Manager will be educated by Nursing Administration on the Fluid Restriction Policy and how to implement a plan for fluid restrictions. The nursing staff will be given written amount of fluid on each meal tray when trays are delivered. Also, all licensed nursing staff are receiving education on Medication Administration policy and Physician Orders policy with a written test to demonstrate knowledge. Medication errors are reported to Risk Management Committee to monitor patterns or trends. The CNO will ensure that pharmacy will report all medication errors to the ACNO who is performing chart audits and to the Risk Manager by way of printed reports. Risk Manager will report number of medication errors to PI. Medication errors will be reviewed, and any action taken logged on a nursing verbal counseling log sheet to monitor patterns and trends. The Chart Audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day. Nursing Administration will maintain a nursing verbal counseling log to include all medication Counselling sessions. Medication errors will be reported though a paper report to the Risk Management committee to monitor patterns or trends.	4/14/19 4/14/19 4/14/19 4/14/19
{A 395}	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview, record review, policy review, review of the facility's Plan of Correction submitted in response to a Statement of Deficiencies dated 01/30/19, and review of facility audits, it was determined that the facility failed to ensure a registered nurse supervised and	{A 395}		

M. K [illegible]

CEO 4/2/19

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(A 395)	Continued From page 23 evaluated the nursing care for three (3) of fifteen (15) sampled patients (Patients #13, #14, and #16). Medical record review revealed the facility failed to administer Patient #16's intravenous (IV) Levaquin (antibiotic medication to treat infections) as prescribed by the physician, on 03/06/19. Patient #16's physician was not notified of the medication omission error by RN #5, as required on 03/06/19. Review of Patient #14's medical record revealed nursing staff (RN #5) incorrectly transcribed a physician's ordered cough medication to Patient #14's Medication Administration Record (MAR). Although, the incorrect medication was not administered, interviews with nursing administration staff revealed they did not identify the errors with Patient #14 and #16 involved the same nurse. Review of Patient #13's physician's orders dated 03/08/19, revealed an order for the patient to receive IV (intravenous) Lasix (diuretic) twice per day; however, there was no documentation in the medical record that the patient received the 6:00 PM dose of Lasix on 03/09/19. Patient #13 also had a physician order for 2000-milliliter fluid restriction; however, record review and interviews with staff revealed nursing staff failed to develop a plan to implement the fluid restriction. Review of the facility's Plan of Correction for the Statement of Deficiencies dated 01/30/19 in which immediate jeopardy for Nursing Services was identified, and review of the facility's audits revealed daily chart audits were being conducted to ensure physician orders were followed and medication administration was accurately conducted; however, the facility's chart audits	(A 395)	In the case of Patient #16 the patient had been discharged and IV access was removed before the 11:00 o'clock dose of IV Levaquin was due. The pharmacist was not notified timely through the EHR that the patient had been discharged. The omission of patient #16's Levaquin was not discovered because the pharmacy was looking at the discharge date and not the discharge time. The pharmacists have been verbally educated on the necessity of looking at the discharge time as well as the date in order to discover all medication errors. The director of pharmacy has counseled the nursing staff to discharge patients from the EHR system as soon as the patient is discharged. Licensed nursing staff will be counseled by ACNO or when ACNO not available by nurse administration to not remove any IV access until patient is ready to leave the facility. Licensed nursing staff will be re-educated by nursing leadership on the Medication Administration Policy and Physician Orders which includes indications for physician notification. Evaluation of the nurse's knowledge is demonstrated through a written test. Patient #14 and #16's med error was by the same RN. The RN received 1:1 counseling and reeducation on the physician orders policy and Medication Administration policy by the ACNO evaluation of the nurse's knowledge was demonstrated through a written test. Also, all licensed nursing staff are receiving education on Medication Administration policy and Physician Orders policy with a written test to demonstrate knowledge. Medication errors are reported to Risk Management Committee to monitor patterns or trends.	4/14/19 4/14/19 4/14/19 4/14/19

M. K [illegible]

CEO 4/2/19

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{A 395}	Continued From page 24 failed to identify Patient#13's Lasixmedication was not administered on 03/09/19, Patient#14's cough medication was incorrectly transcribed, or that Patient #16 did not receive IV Levaquin as prescribed on 03/06/19. The findings include: Review of the "Medication Administration" Policy dated 02/2017 revealed Antibiotics were time-critical scheduled medications, which could have a significant or negative impact on the intended pharmacological or therapeutic effect of the medication. The policy stated Antibiotics should be administered as ordered by the physician, and in the event the medication was not administered as ordered, the patient's physician should be notified related to the error, which would be a result of a missed dose of the medication. The policy included "A. All medication administrations will be performed through the electric MAR in the computer.. F. The nurse that will administer the medication is responsible for the preparation of the medication and the documentation on the MAR and on the Nursing Daily Flowsheet if indicated." Review of the "Continuum of Care/Techniques for Charting" Policy dated 02/2019 revealed "The nursing department will document the patient stay in the facility in such a manner to provide a comprehensive understanding of the patient's well-being...Procedure for Charting...8. Document all medications with date, times and initials on the MAR.." Review of the Plan of Correction for the Statement of Deficiencies dated 01/30/19 revealed "Chart audits, including timely medication administration, medication omissions,	{A 395}	Patient #13 had order for a fluid restriction but had no plan to carry out the order. Also, Patient #13 missed a dose of Lasix. The nurse aides will be educated on the fluid restriction policy by Nurse Administration. The primary nurse of the patient will be responsible for reviewing the Medact the electronic Kardex for nursing orders and ensuring that the nurse aides are knowledgeable of the patient's diet order including fluid restrictions from the patient's nurse each shift. A sign will be posted above the patient's bed for further clarification for all dietary restrictions. Nursing staff and the Dietary Manager will be educated by Nursing Administration on the Fluid Restriction Policy and how to implement a plan for fluid restrictions. The nursing staff will be given written amount of fluid on each meal tray when trays are delivered. The CNO will ensure that pharmacy will report all medication errors to the ACNO who is performing chart audits and to the Risk Manager by way of printed reports. Risk Manager will report number of medication errors to PI. Medication errors will be reviewed, and any action taken logged on a nursing verbal counseling log sheet to monitor trends. Nursing staff and the Dietary Manager will be educated by Nursing Administration on the Fluid Restriction Policy and how to implement a plan for fluid restrictions. The nursing staff will be given written amount of fluid on each meal tray when trays are delivered. The CNO will ensure that pharmacy will report all medication errors to the ACNO who is performing chart audits and to the Risk Manager by way of printed reports. Risk Manager will report number of medication errors to PI. Medication errors will be reviewed, and any action taken logged on a nursing verbal counseling log sheet to monitor trends.	4/14/19 4/14/19 4/14/19 4/14/19 4/14/19

M. K Cu

CEO 4/2/19

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(A 395)	Continued From page 25 change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily...Chart audit tools are collected by the ACNO who will report results of the chart audits ..to QAPI weekly so if needed immediate actions are taken." The facility added to the audit tool on 03/08/19 that the facility would monitor to ensure physician orders were completed correctly. 1. Review of Patient #16's medical record revealed the patient was admitted to the facility on 03/02/19 with a diagnosis of Acute Pyelonephritis. Review of Patient #16's physicians orders dated 03/03/19, included Levaquin (antibiotic) 750 milligrams (mg) intravenous (IV) to be administered daily. Review of Patient #16's physician progress notes dated 03/05/19, revealed the physician documented the patient's discharge home would be planned the following morning (03/06/19) and to continue the patients IV antibiotics. However, review of Patient #16's Medication Administration Record (MAR) revealed staff failed to administer Patient #16's IV antibiotic (Levaquin) on 03/06/19, as prescribed. Interview with Registered Nurse (RN) #5 on 03/07/19 at 10:45 AM revealed she did not administer Patient #16's IV Antibiotic (Levaquin) as prescribed by the physician on 03/06/19. She stated medications that were not administered as directed by the physician, were considered a medication error because the medication was omitted. She stated the patient's physician should be notified when a medication was not administered as ordered. However, RN #5 did	(A 395)	The Chart Audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day. Nursing Administration will maintain a nursing verbal counseling log to include all medication Counselling sessions. Medication errors will be reported though a paper report to the Risk Management committee to monitor patterns or trends. The CEO is a member of the PI Committee. Data on medication errors is reported at the P&T Committee, the PI Committee, and is forwarded to the MEC and Governing Board.	4/14/19 4/14/19

M. L [illegible] CEO 4/2/19

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(A 395)	Continued From page 26 not contact Patient #16's physician when the IV Antibiotic was not administered as ordered on 03/06/19. Interview with the Assistant Chief Nursing Officer (ACNO) on 03/07/19 at 3:25 PM revealed she had conducted a chart audit of Patient #16's medical record on 03/06/19, and had not identified the medication error. She stated she was unsure why the medication error had not been identified. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she was monitoring daily for medication errors, and when medications were omitted it was a medication error. Even though, the medication error had occurred approximately forty-eight (48) hours prior to the interview being conducted, she had not identified that Patient #16 had not received the IV Antibiotic Levaquin as prescribed, on 03/06/19. The Pharmacist also stated, "We should have caught that," and was unsure why the medication error had not been identified. 2. Review of Patient #13's medical record revealed the hospital admitted the patient on 03/08/19 with a diagnosis of Congestive Heart Failure (CHF). The patient's physician orders dated 03/08/19 included daily weights, monitoring intake and output, and administering Lasix (diuretic) 40 milligrams (mg) IV twice per day. In addition, on 03/09/18, a physician's order was received for a 2000-milliliter (ml) fluid restriction. However, further review of Patient #13's medical record revealed no documentation that the 6:00 PM scheduled dose of Lasix was administered and no documentation related to how nursing	(A 395)		

M. L Cm

CEO 4/2/19

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(A 395)	Continued From page 27 staff planned to implement the patient's 2000 ml fluid restriction. Interview with RN #2 on 03/12/19 at 1:40 PM revealed he was responsible for Patient #13's care on 03/09/19 during the day shift (7 AM to 7 PM). RN #2 stated he failed to document the administration of Patient #13's medication. Per the RN, he administered the medication at approximately 5:00 PM because the patient wanted the medication early to ensure he/she was not up all night using the restroom. The RN stated his routine was to pull the medication from the Omnicell (machine stocked with medication), use the paper Medication Administration Record (MAR), give the medication to the patient, and then document that the medication was administered in the Computer on Wheels (COW). The RN stated he knew the procedure was to utilize the COW when giving medications and to document on the computerized MAR, but he did not always follow procedure. Review of the daily audit tool (Medical-Surgical Chart Audit Tool) dated 03/08/19 through 03/11/19 revealed there were four (4) to six (6) patients on the medical-surgical unit between 03/08/19 and 03/11/19. The tool included a category of timely administration of medication, medication omissions, etc. On 03/09/19, the audit tool failed to include a review of Patient #13's medical record. Review of 03/10/19 and 03/11/19 audit sheets revealed staff had reviewed Patient #13's medical record, but had not identified any problems with medication administration or that the ordered Lasix was not documented as administered on 03/09/19. Interview with Assistant Chief Nursing Officer	(A 395)		

CGO 4/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 395}	Continued From page 28 (ACNO) and RN #8 on 03/12/19 at 8:45 AM revealed they did the Medical-Surgical Chart Audit for 03/09/19. The ACNO stated she completed the audit for 03/09/19 at approximately 10:00 AM. She stated she reviewed records for documentation since 12:00 AM that morning, and conducted the audit for the same time frame the next day. The ACNO stated she saw now she was doing the audits incorrectly and should be looking at a 24-hour period. The ACNO stated they did not identify that Patient #13's Lasix was not documented as given for the 6:00 PM dose on 03/09/19. Interview with Nurse Aide #1 on 03/11/19 at 4:40 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home. The Nurse Aide stated she had served the patient breakfast and had also given him/her an additional juice. The Nurse Aide stated the meal tray contained the following fluids: coffee, milk, and juice. Per the Nurse Aide, she was not aware Patient #13 was on fluid restrictions. Interview with RN #7 on 03/11/19 at 4:57 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home (mid-morning, 03/11/19). Per the RN, she had also given the patient juice that morning. The RN stated the patient was on a 2000 ml fluid restriction and pointed out the restriction on the facility Med Act (Kardex used for nursing orders). However, there was no specific plan on the Kardex as to how the fluid restriction would be implemented and the intake record for that morning (03/11/19) showed the patient had consumed 960 ml by 8:00 AM. Interview with the Assistant Director of Nursing	{A 395}		

M. K Cm CEO 4/2/19

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(A 395)	Continued From page 29 (ACNO) and RN #8 on 03/12/19 at 8:45 AM revealed she and RN #8 had completed the charts audits for 03/09/18. The ACNO reviewed Patient #13's record, could not find a plan for implementing the fluid restriction, and stated, "We should have had a plan for the fluid restriction." The ACNO said nursing should have been providing part of the fluids and dietary the other part. The ACNO stated the lack of planning for the fluid restriction had not being identified on the chart audit. 3. Review of Patient #14's medical record revealed the patient was admitted to the facility on 03/06/19 with diagnoses, which included Chronic Obstructive Pulmonary Disease (COPD) and Anemia. Review of Patient #14's physician orders revealed Physician #4 ordered Robitussin (Dextromethorphan) DM (treats cough and congestion) one (1) or two (2) teaspoons (tsps.) to be administered by mouth four times daily, as needed. Review of the Medication Error Tracking Form dated 03/07/19 revealed pharmacy staff identified on 03/07/19 at 5:21 PM that RN #5 had entered Tussionex (treats coughs and common cold and allergies) into the facility medication administration system, instead of entering the medication (Robitussin) that was ordered by the physician. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she had identified a transcription error on 03/07/19, where RN #5 had transcribed a medication ordered incorrectly for Patient #14. She stated the error was identified,	(A 395)		

M. K Cm CGD 4/2/19

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{A 395}	Continued From page 30 and the patient never received the wrong medication. The Pharmacist stated she notified the Chief Nursing Officer (CNO) of the error when it was identified on 03/07/19. Interview with the CNO on 03/08/19 at 9:50 AM revealed she was notified of RN #5's medication omission error for Patient #16 and the RN's transcription error identified by the Pharmacist related to Patient #14 on 03/07/19. She stated she had not conducted any re-education with the RN after being notified of the errors. Interview with the Chief Executive Officer (CEO) on 03/08/19 at 10:15 AM revealed he had not been notified of RN #5's medication errors; however, he stated he should have been.	{A 395}		

M. K [signature] CEO 4/2/19

Office of Inspector General

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(E 000)	Initial Comments An on-site revisit was conducted on 03/07-12/19. Tags E3060, E3440, and E3660 were determined to be corrected as alleged. However, the facility remained out of compliance with tags E0041 and E2340.	(E 000)		
(E 041)	902 KAR 20:016 3(2)(a)2 Section 3. Administration and Operation (2) Administrator. (a) The administrator shall: 2. Be responsible for the management of the hospital; This requirement is not met as evidenced by: Based on interview, record review, and review of Governing Body Meeting minutes, facility audits, Daily Operating Budget, and the Plan of Correction the facility submitted for the statement of deficiencies issued on 01/30/19, it was determined that the facility failed to ensure the Chief Executive Officer (CEO) was responsible for managing the hospital budget and implementing the Plan of Correction. The CEO failed to ensure the operating budget included current revenues and debts. In addition, the CEO failed to ensure staff training and audits were completed in accordance with the facility's Plan of Correction. The findings include: Review of the Governing Body Meeting minutes dated 02/22/19 revealed the CEO was approved to serve as the Interim CEO effective 02/27/19. 1. The Pharmacy Supplier who supplied the	(E 041)	The CEO will revise budgeted revenues and debts for FY19 and submit to board for approval at the next board meeting scheduled for 4/11/19. The review budget will show amounts to repay loans and drug supplier. The CEO will ensure the facility pays tax liabilities to the federal, state, and city taxing authorities on an ongoing basis. This will be done by way of agreements made in March 2019 with the taxing authorities.	4/14/19 4/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. [signature] TITLE: CEO (X6) DATE: 3/29/19

Office of Inspector General

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(E 041)	Continued From page 1 hospital with medication was contacted during the revisit and information from the pharmacy was received on 03/13/19 and 03/14/19. Review of information received via email on 03/13/19 from the facility's Pharmacy Supplier revealed the facility was behind approximately $115,000 on their payment plan and another $27,000 was due on 03/20/19. Additional information received on 03/14/19 revealed the company that owns the hospital had paid approximately $89,000 toward their past due amount in order to receive shipments. However, continued to owe the Pharmacy Supplier a total of $377,000. Per information received on 03/14/19 from the supplying pharmacy, the decision whether to provide medications to the facility is determined each time an order is placed. Review of the daily operating budget revealed the revenue and expenses were listed on a monthly basis for the current fiscal year July 2018 through June 2019. However, the daily budget did not include payments for outstanding debts (loans, debt owed to the Pharmacy Supplier). In addition, the revenue section included a Disproportionate Share Hospital (DSH) revenue of $99,000 per month from January 2019 through June 2019. Interview with the Chief Executive Officer (CEO) on 03/07/19 at 11:27 AM, 2:20 PM, and 4:12 PM, on 03/08/19 at 2:10 PM, and on 03/12/19 at 2:02 PM revealed the Governing Body Board had met on 02/22/19 and appointed him as CEO. The CEO stated he and the owner developed the budget; however, the CEO stated the repayment of debt was not included in the budget. Per the CEO, even though the facility was still in debt to the contracted pharmacy and was making payments of $28,000 per month to repay the	(E 041)	CEO is attending current weekly PI meetings where nursing chart audit results are reported and medication errors from Risk Management are reported. Inservice's offered and evaluations are reported in these weekly PI meetings.	4/14/19

M. K [illegible] CEO 3/29/19

Office of Inspector General

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(E 041)	Continued From page 2 debt, the debt was not included in the budget. Further interview with the CEO revealed employee taxes (Federal, State, and City) for the fourth quarter (October - December) of 2018 had not been paid. The CEO stated the taxes had been withheld from the employees' pay checks, but had not yet been paid to the federal, state, or city governments. In addition, the facility had not paid employee state taxes for February 2019. Continued interview with the CEO revealed the hospital did not have the funds to pay employees on 03/01/19, but did not know until late afternoon on 03/01/19 that funds were not available. Per the CEO, direct care staff were not paid until 03/07/19 and administrative staff were paid at 2:00 PM on 03/08/19. The CEO stated funds for the 03/15/19 payroll were not available as of 03/12/19. Continued interview with the CEO revealed when calculating the budget for January 2019 through June 2019, he included $99,000 of revenue per month that was expected from DSH Payments. However, the expected DSH payment would not be received until November 2019 (which is not in the same fiscal year). 2. Review of the Plan of Correction (POC) submitted for the Statement of Deficiencies (SOD) dated 01/30/19 revealed the CEO was responsible for ensuring staff were trained/in-serviced. Interview with the Assistant Chief Nursing Officer (ACNO) on 03/08/19 at 2:25 PM revealed, "We tried to do as much of the training/in-service in person with the nursing staff; however, some of the policies were given to the staff and the staff were expected to read the policy and sign the in-service roster. We did not ensure the staff had	(E 041)	Licensed nursing staff will not be given the policy to read and a sign-in roster. All in-services will be conducted by nursing leadership using small group sessions or one on one on Medication Administration Policy and Physician Orders Policy and this will be evaluated through written test. CEO is notified through weekly PI reports of all training / in-services method of in-service /training and percentage of attendance and evaluation results.	4/14/19

M. L. Eiland CEO 3/29/19

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{E 041}	Continued From page 3 completed the in-services." Interview with Licensed Practical Nurse (LPN) #1 on 03/08/19 at 2:30 PM and with Registered Nurse (RN) #2 on 03/12/19 at 1:40 PM confirmed some of the recent in-service training (included on plan of correction) consisted of a policy being left for staff to read and signing a training roster . LPN #1 also stated there was a book at the nurses' station with the policies. 3. Review of the Plan of Correction (POC) submitted for the Statement of Deficiencies (SOD) dated 01/30/19 revealed the CEO would be responsible to ensure adequate resources were available, allow staff sufficient time to participate in Quality Assurance Performance Improvement (QAPI) activities, and institute appropriate information systems for collection and analyzing data. The plan further stated the CEO would report any and all findings to the governing body. 3. A. Review of Patient #16's medical record revealed the facility admitted the patient on 03/02/19 with a diagnosis of Acute Pyelonephritis. Review of Patient #16's physician orders dated 03/03/19, included an order for Levaquin (antibiotics) 750 milligrams (mg) intravenous (IV) to be administered daily. Review of Patient #16's physician progress notes dated 03/05/19, revealed the physician documented the patient's discharge home would be planned the following morning (03/06/19) and to continue the patient's IV antibiotics. However, review of Patient #16's Medication Administration Record (MAR) revealed staff failed to administer Patient #16's IV antibiotics on 03/06/19, as	{E 041}		

M. L CEO 3/29/19

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{E 041}	Continued From page 4 prescribed. Interview with Registered Nurse (RN) #5 on 03/07/19 at 10:45 AM revealed she had not administered Patient #16's IV Antibiotic (Levaquin) as prescribed by the physician on 03/06/19. Interview with the Assistant Chief Nursing Officer (ACNO) on 03/07/19 at 3:25 PM revealed she had conducted a chart audit of Patient #16's medical record on 03/06/19, but had not identified the medication error. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she was monitoring daily for medication errors in the facility, and when medications were omitted, it was a medication error. Per the Pharmacist, she had not identified that Patient #16 had not received the IV Antibiotic Levaquin as prescribed on 03/06/19. 3. B. Review of Patient #13's medical record revealed the hospital admitted the patient on 03/08/19 with a diagnosis of Congestive Heart Failure (CHF). The physician's orders dated 03/08/19 included an order for Lasix 40 milligrams (mg) IV twice per day. In addition, on 03/09/18, an order for a 2000-milliliter (ml) fluid restriction was received. However, further review of the medical record revealed no documentation that the 6:00 PM scheduled dose of Lasix was administered and no documentation related to how nursing staff planned to implement the patient's 2000 ml fluid restriction. Review of the Plan of Correction for the 01/30/19 Statement of Deficiencies revealed daily chart	{E 041}	The Chart Audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day. Nursing Administration will maintain a nursing verbal counseling log to include all medication Counselling sessions. Medication errors will be reported though a paper report to the Risk Management committee to monitor patterns or trends. In the case of Patient #16 the patient had been discharged and IV access was removed before the 11:00 o'clock dose of IV Levaquin was due. The pharmacist was not notified timely through the EHR that the patient had been discharged. The omission of patient #16's Levaquin was not identified because the pharmacy was looking at the discharge date and not the discharge time. The pharmacists have been verbally educated on the necessity of looking at the discharge time as well as the date in order to discover all medication errors. The director of pharmacy has counseled the nursing staff to discharge patients from the EHR system as soon as the patient is discharged. Licensed nursing staff will be counseled by nurse administration to not remove any IV access until patient is ready to leave the facility.	4/14/19 4/14/14

M. K CEO 3/25/19

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{E 041}	Continued From page 5 audits would be completed. Review of the chart audit tool revealed the hospital was monitoring to ensure physician orders were completed correctly; medications were administered timely, etc. Review of the tool for 03/08/19 through 03/11/19 revealed the hospital had not identified that a dose of Lasix was not documented as given on 03/09/19 or that there was not plan for implementing the Patient #13's fluid restriction. Review of the daily audit tool (Medical-Surgical Chart Audit Tool) dated 03/08/19 through 03/11/19 revealed there four (4) to six (6) patients on the medical-surgical unit between 03/08/19 and 03/11/19. The tool included a category to audit timely administration of medication, medication omissions, etc. On 03/09/19, the audit tool failed to include a review of Patient #13. Review of 03/10/19 and 03/11/19 audit sheets revealed staff had reviewed Patient #13's medical record, but had not identified any problems with medication administration or that the ordered Lasix was not documented as administered on 03/09/19. Interview with Assistant Director of Nursing (ADON) and RN #8 on 03/12/19 at 8:45 AM revealed they did the Medical-Surgical Chart Audit for 03/09/19. The ADON stated she completed the audit for 03/09/19 at approximately 10:00 AM. She stated she reviewed documentation that had been completed since 12:00 AM, and stated the next day the same time frame would be reviewed. The ADON stated she saw now she was doing the audit wrong and should be looking at a 24-hour period. The ADON stated they did not identify that Patient #13's Lasix was not documented as given for the 6:00 PM dose on 03/09/19. Interview with Nurse Aide #1 on 03/11/19 at 4:40	{E 041}		

M. K CEO 3/25/19

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{E 041}	Continued From page 6 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home. Per the Nurse Aide, she was not aware Patient #13 was on fluid restrictions. Interview with RN #7 on 03/11/19 at 4:57 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home (mid-morning, 03/11/19). The RN stated the patient was on a 2000 ml fluid restriction and pointed out that the restriction was documented on the facility Med Act (Kardex used for nursing orders); however, there was no specific plan as to how the fluid restriction would be implemented. The intake record for that morning showed the patient had consumed 960 ml by 8:00 AM. Interview with the Assistant Director of Nursing (ADON) and RN #8 on 03/12/19 at 8:45 AM revealed she and RN #8 had completed the charts audits for 03/09/18. The ADON reviewed Patient #13's record and could not find a plan for implementing the fluid restriction. The ADON stated the lack of planning for the fluid restriction had not being identified on the chart audit. Interview with the CEO on 03/08/19 at 10:00 AM revealed he attended the weekly QAPI Meetings and that he was monitoring staff training. The CEO stated he had "learned today" (after identified by the surveyors) that some staff had not received training. The CEO stated he was not aware that the staff training consisted of staff reading a policy and signing an in-service record. The CEO said he thought the training would be 1:1 or in a group setting with some sort of testing after the training. The CEO further stated he had not been notified of any concerns with the chart audits and was not aware of any medication errors or omissions.	{E 041}	In March 2019, a policy and procedure were developed on Fluid Restriction. Nursing staff will be in-serviced by nursing administration on the Fluid Restriction Policy which includes placement of the fluid restriction plan on the Medact which is the electronic Kardex for nursing orders. The Registered Dietician will provide further education on fluid restriction diet to nursing staff. Evaluation of knowledge will be demonstrated through a written test. The CEO will receive a weekly report through the PI Committee of all nursing staff training/in-services, method of training/in-service, percentage of attendance, and evaluation results.	4/14/19 4/14/19

M. K [illegible] CEO 3/25/19

Office of Inspector General

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(E2340)	902 KAR 20.016 4(2)(g) Section 4 Provision of Services (2) Nursing service. (g) A registered nurse shall assign staff and evaluate the nursing care of each patient in accordance with the patient's need and the nursing staff available. This requirement is not met as evidenced by: Based on interview, record review, policy review, review of the facility's Plan of Correction submitted in response to a Statement of Deficiencies dated 01/30/19, and review of facility audits, it was determined that the facility failed to ensure a registered nurse supervised and evaluated the nursing care for three (3) of fifteen (15) sampled patients (Patients #13, #14, and #16). Medical record review revealed the facility failed to administer Patient #16's intravenous (IV) Levaquin (antibiotic medication to treat infections) as prescribed by the physician, on 03/06/19. Patient #16's physician was not notified of the medication omission error by RN #5, as required on 03/06/19. Review of Patient #14's medical recordrevealed nursing staff (RN #5) incorrectly transcribed a physician's ordered cough medication to Patient #14's Medication Administration Record (MAR). Although, the incorrect medication was not administered, interviews with nursing administration staff revealed they did not identify the errors with Patient #14 and #16 involved the same nurse. Review of Patient #13's physician's orders dated 03/08/19, revealed an order for the patient to receive IV (intravenous) Lasix (diuretic) twice per	(E2340)	RN #5 was identified as being the same nurse involved in the med errors on Patient #14 and #16. This RN #5 received 1:1 counselling and re-education on the Physician Orders policy and Medication Administration policy by ACNO. Evaluation of the nurse's knowledge will be demonstrated through a written test. Licensed nursing staff will be re-educated on Medication Administration Policy and Physician Orders Policy by Nursing Leadership. Evaluation of the nurse's knowledge will be demonstrated through a written test.	4/14/19 4/14/19

M. K CEO 3/29/19

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M. K [signature] CEO 3/29/19

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{E2340}	Continued From page 9 and the documentation on the MAR and on the Nursing Daily Flowsheet if indicated." Review of the "Continuum of Care/Techniques for Charting" Policy dated 02/2019 revealed "The nursing department will document the patient stay in the facility in such a manner to provide a comprehensive understanding of the patient's well-being...Procedure for Charting...8. Document all medications with date, times and initials on the MAR..." Review of the Plan of Correction for the Statement of Deficiencies dated 01/30/19 revealed "Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily...Chart audit tools are collected by the ACNO who will report results of the chart audits...to QAPI weekly so if needed immediate actions are taken." The facility added to the audit tool on 03/08/19 that the facility would monitor to ensure physician orders were completed correctly. 1. Review of Patient #16's medical record revealed the patient was admitted to the facility on 03/02/19 with a diagnosis of Acute Pyelonephritis. Review of Patient #16's physicians orders dated 03/03/19, included Levaquin (antibiotic) 750 milligrams (mg) intravenous (IV) to be administered daily. Review of Patient #16's physician progress notes dated 03/05/19, revealed the physician documented the patient's discharge home would be planned the following morning (03/06/19) and to continue the patients IV antibiotics. However, review of Patient #16's Medication Administration	{E2340}	The Chart Audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day. Nursing Administration will maintain a nursing verbal counseling log to include all medication Counselling sessions. Medication errors will be reported though a paper report to the Risk Management committee to monitor patterns or trends.	4/14/19

M. K CEO 3/29/19

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M. K CGD 3/29/19

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(E2340)	Continued From page 10 Record (MAR) revealed staff failed to administer Patient #16's IV antibiotic (Levaquin) on 03/06/19, as prescribed. Interview with Registered Nurse (RN) #5 on 03/07/19 at 10:45 AM revealed she did not administer Patient #16's IV Antibiotic (Levaquin) as prescribed by the physician on 03/06/19. She stated medications that were not administered as directed by the physician, were considered a medication error because the medication was omitted. She stated the patient's physician should be notified when a medication was not administered as ordered. However, RN #5 did not contact Patient #16's physician when the IV Antibiotic was not administered as ordered on 03/06/19. Interview with the Assistant Chief Nursing Officer (ACNO) on 03/07/19 at 3:25 PM revealed she had conducted a chart audit of Patient #16's medical record on 03/06/19, and had not identified the medication error. She stated she was unsure why the medication error had not been identified. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she was monitoring daily for medication errors, and when medications were omitted it was a medication error. Even though, the medication error had occurred approximately forty-eight (48) hours prior to the interview being conducted, she had not identified that Patient #16 had not received the IV Antibiotic Levaquin as prescribed, on 03/06/19. The Pharmacist also stated, "We should have caught that," and was unsure why the medication error had not been identified. 2. Review of Patient #13's medical record	(E2340)	In the case of Patient #16 the patient had been discharged and IV access was removed before the 11:00 o'clock dose of IV Levaquin was due. The pharmacist was not notified timely through the EHR that the patient had been discharged. The omission of patient #16's Levaquin was not discovered because the pharmacy was looking at the discharge date and not the discharge time. The pharmacists have been verbally educated on the necessity of looking at the discharge time as well as the date in order to discover all medication errors. The director of pharmacy has counseled the nursing staff to discharge patients from the EHR system as soon as the patient is discharged. Licensed nursing staff will be counseled by ACNO or when ACNO not available by nurse administration to not remove any IV access until patient is ready to leave the facility.	4/14/19

M. L. Cook CEO 3/28/19

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{E2340}	Continued From page 11 revealed the hospital admitted the patient on 03/08/19 with a diagnosis of Congestive Heart Failure (CHF). The patient's physician orders dated 03/08/19 included daily weights, monitoring intake and output, and administering Lasix (diuretic) 40 milligrams (mg) IV twice per day. In addition, on 03/09/18, a physician's order was received for a 2000-milliliter (ml) fluid restriction. However, further review of Patient #13's medical record revealed no documentation that the 6:00 PM scheduled dose of Lasix was administered and no documentation related to how nursing staff planned to implement the patient's 2000 ml fluid restriction. Interview with RN #2 on 03/12/19 at 1:40 PM revealed he was responsible for Patient #13's care on 03/09/19 during the day shift (7 AM to 7 PM). RN #2 stated he failed to document the administration of Patient #13's medication. Per the RN, he administered the medication at approximately 5:00 PM because the patient wanted the medication early to ensure he/she was not up all night using the restroom. The RN stated his routine was to pull the medication from the Omnicell (machine stocked with medication), use the paper Medication Administration Record (MAR), give the medication to the patient, and then document that the medication was administered in the Computer on Wheels (COW). The RN stated he knew the procedure was to utilize the COW when giving medications and to document on the computerized MAR, but he did not always follow procedure. Review of the daily audit tool (Medical-Surgical Chart Audit Tool) dated 03/08/19 through 03/11/19 revealed there were four (4) to six (6) patients on the medical-surgical unit between 03/08/19 and	{E2340}	Some 1:1counselling is being done with RN staff by nurse administration on Medication Administration Policy and Physician Orders Policy. Evaluation of the knowledge will be demonstrated through a written test. Due to continued medication errors, licensed nursing staff will be re-educated on Medication Administration Policy, Physician Orders Policy. RN #2 received 1:1 counseling and re-education on Medication Administration policy and Physician Order policy. Evaluation of RN #2's knowledge of policies will be demonstrated through a written test and verbalization of proper procedure of medication administration. RN #2 was counselled on importance of always following hospital policy and procedures.	4/14/19 4/14/19

M.K. CEO 3/29/19

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(E2340)	Continued From page 12 03/11/19. The tool included a category of timely administration of medication, medication omissions, etc. On 03/09/19, the audit tool failed to include a review of Patient #13's medical record. Review of 03/10/19 and 03/11/19 audit sheets revealed staff had reviewed Patient #13's medical record, but had not identified any problems with medication administration or that the ordered Lasix was not documented as administered on 03/09/19. Interview with Assistant Chief Nursing Officer (ACNO) and RN #8 on 03/12/19 at 8:45 AM revealed they did the Medical-Surgical Chart Audit for 03/09/19. The ACNO stated she completed the audit for 03/09/19 at approximately 10:00 AM. She stated she reviewed records for documentation since 12:00 AM that morning, and conducted the audit for the same time frame the next day. The ACNO stated she saw now she was doing the audits incorrectly and should be looking at a 24-hour period. The ACNO stated they did not identify that Patient #13's Lasix was not documented as given for the 6:00 PM dose on 03/09/19. Interview with Nurse Aide #1 on 03/11/19 at 4:40 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home. The Nurse Aide stated she had served the patient breakfast and had also given him/her an additional juice. The Nurse Aide stated the meal tray contained the following fluids: coffee, milk, and juice. Per the Nurse Aide, she was not aware Patient #13 was on fluid restrictions. Interview with RN #7 on 03/11/19 at 4:57 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home (mid-morning, 03/11/19). Per the RN, she had	(E2340)	The nurse aides will be educated on the fluid restriction policy by Nurse Administration. The primary nurse of the patient will be responsible for reviewing the Medact the electronic Kardex for nursing orders and ensuring that the nurse aides are knowledgeable of the patient's diet order including fluid restrictions from the patient's nurse each shift. A sign will be posted above the patient's bed for further clarification for all dietary restrictions. Nursing staff and the Dietary Manager will be educated by Nursing Administration on the Fluid Restriction Policy and how to implement a plan for fluid restrictions. The nursing staff will be given written amount of fluid on each meal tray when trays are delivered.	4/14/19

M. K. Gu CEO 3/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100020	A. BUILDING: _____ B. WING _____	R-C 03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(E2340)	Continued From page 13 also given the patient juice that morning. The RN stated the patient was on a 2000 ml fluid restriction and pointed out the restriction on the facility Med Act (Kardex used for nursing orders). However, there was no specific plan on the Kardex as to how the fluid restriction would be implemented and the intake record for that morning (03/11/19) showed the patient had consumed 960 ml by 8:00 AM. Interview with the Assistant Director of Nursing (ACNO) and RN #8 on 03/12/19 at 8:45 AM revealed she and RN #8 had completed the charts audits for 03/09/18. The ACNO reviewed Patient #13's record, could not find a plan for implementing the fluid restriction, and stated, "We should have had a plan for the fluid restriction." The ACNO said nursing should have been providing part of the fluids and dietary the other part. The ACNO stated the lack of planning for the fluid restriction had not being identified on the chart audit. 3. Review of Patient #14's medical record revealed the patient was admitted to the facility on 03/06/19 with diagnoses, which included Chronic Obstructive Pulmonary Disease (COPD) and Anemia. Review of Patient #14's physician orders revealed Physician #4 ordered Robitussin (Dextromethorphan) DM (treats cough and congestion) one (1) or two (2) teaspoons (tsps.) to be administered by mouth four times daily, as needed. Review of the Medication Error Tracking Form dated 03/07/19 revealed pharmacy staff identified on 03/07/19 at 5:21 PM that RN #5 had entered Tussionex (treats coughs and common cold and	(E2340)		

M. K [illegible] CEO 3/29/19

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(E2340)	Continued From page 14 allergies) into the facility medication administration system, instead of entering the medication (Robitussin) that was ordered by the physician. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she had identified a transcription error on 03/07/19, where RN #5 had transcribed a medication ordered incorrectly for Patient #14. She stated the error was identified, and the patient never received the wrong medication. The Pharmacist stated she notified the Chief Nursing Officer (CNO) of the error when it was identified on 03/07/19. Interview with the CNO on 03/08/19 at 9:50 AM revealed she was notified of RN #5's medication omission error for Patient #16 and the RN's transcription error identified by the Pharmacist related to Patient #14 on 03/07/19. She stated she had not conducted any re-education with the RN after being notified of the errors. Interview with the Chief Executive Officer (CEO) on 03/08/19 at 10:15 AM revealed he had not been notified of RN #5's medication errors; however, he stated he should have been.	(E2340)	The CNO will ensure that pharmacy will report all medication errors to the ACNO who is performing chart audits and to the Risk Manager by way of printed reports. Risk Manager will report number of medication errors to PI. Medication errors will be reviewed, and any action taken logged on a nursing verbal counseling log sheet to monitor trends.	4/14/19

M. K CEO 3/29/19

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	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

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SOUTHEASTERN KY MEDICAL CENTER	830 FUVERVIEW AVENUE PINEVILLE, KY 40977

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A 000	INITIAL COMMENTS A complaint investigation (KY29068) was initiated on 01/22/19 and concluded on 01/30/19. The complaint was substantiated and the facility was determined to be out of compliance with the Conditions of Participation at 42 CFR 482.12 Governing Body (A0043), 42 CFR 482.13 Patient Rights (A0115), 42 CFR 482.21 Quality Assurance and Performance Improvement (A0263), 42 CFR 482.23 Nursing Services (A0385), 42 CFR 482.25 Pharmaceutical Services (A0489), 42 CFR 482.43 Discharge Planning (A0799), 42 CFR 482.51 Surgical Services (A0940), and 42 CFR 482.55 Emergency Services (A1100). Immediate Jeopardy was determined to exist on 01/30/19, and is ongoing in the areas of Governing Body, Patient Rights, QAPI, Nursing Services, Pharmaceutical Services, Discharge Planning, Surgical Services, and Emergency Services. Standard level deficiencies were identified at Governing Body (A0057 and A0073), Patient Rights (A0145), QAPI (A0273), Nursing Services (A0395), Pharmaceutical Services (A0490), Dicharge Planning (A0837), Surgical Services (A0951 and A0955), and Emergency Services (A1103 and A1104). The facility was notified of the Immediate Jeopardy on 01/30/19. The facility failed to protect the rights of six patients from neglect. Observations revealed the facility provided Emergency Department (ED) services and surgical services (services were limited to general surgery), and had a twelve (12) bed medical surgical inpatient unit. Interviews revealed the facility did not provide intensive/critical care services and had no policy/procedure in place regarding the scope of	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	3/4/19

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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A 000	Continued From page 1 services that the medical surgical unit could provide. Subsequently, the facility admitted Patients #2, #8, and #11 for treatment of diagnoses that the facility could not provide. The facility failed to ensure nursing services were organized to provide twenty-four hour care. The facility failed to have a system for consulting the Registered Dietitian (RD) when patients had feeding tubes, pressure ulcers/wounds, or Diabetes; failed to have an effective system to ensure patients received physician ordered diets; failed to administer medications per physician orders; failed to notify physicians when patients had a change in condition or when their medications were not available; and failed to assess/provide treatment for a patient's pressure sore. The RD stated he had only consulted on one patient in the approximately eight months that he had been contracted with the facility. The facility failed to have a Pharmacy Distributor to supply medications to the facility due to outstanding debt. Observation, interview, and record review revealed the facility failed to have medications that were required by the facility's formulary; including antibiotics, intravenous fluids, and medications required for emergencies including Verapamil (used to treat high blood pressure, chest pain, and heart arrhythmia), Epinephrine (used to treat life-threatening allergic reactions and cardiac arrest), and Sodium Bicarbonate (used in emergencies for cardiac arrest and metabolic acidosis). In addition, the facility only had one Activase (used to treat blood clots in patients having heart attacks and strokes). Interviews revealed the facility was unsure how they were going to obtain medications for use at the facility.	A 000		

Signature: _____ Date: 2/4/19

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A 000	Continued From page 2 The facility failed to ensure Patient #9 was referred to appropriate agencies for follow-up. On 01/16/19 at 5:30 PM, a social services consult was requested for Patient #9 because the patient did not have running water at home and did not have transportation to/from appointments or the pharmacy. However, the facility failed to conduct a social services consult and discharged Patient #9 home on 01/23/19. The facility failed to have surgical services that achieved and maintained a high maintenance of medical practice and patient care. On 08/16/18, Patient #1 was admitted for abdominal pain and signed a consent to have an Esophagogastroduodenoscopy (EGD) (a procedure to examine the stomach and upper portion of the small intestine). However, review of the "Operating Room Nurses Note" and a facility investigation revealed the facility attempted to perform a colonoscopy (a procedure to examine the colon from the rectum) and performed a sigmoidoscopy (examined the inner part of the rectum and lower colon) without the patient's consent. The facility failed to meet the emergency needs of patients in accordance with acceptable standards of practice. Patient #12 presented to the Emergency Department (ED) on 12/04/18, in full cardiac arrest. On two different occasions, Patient #12 required multiple doses of Epinephrine (a medication to stimulate the heart) in an effort to sustain the patient's life. However, the facility failed to have enough medication to treat the patient, and medication had to be supplied to the facility by the Emergency Medical Services (EMS) that had transported the patient	A 000		

Signature: _____ Date: 3/4/19

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A 000	Continued From page 3 to the ED. On 07/17/18, EMS was attempting to transfer a patient to the ED who was exhibiting signs and symptoms of an acute stroke. However, when EMS contacted the ED to inform them that they were en route with the patient, they were informed by RN #11 not to bring the patient to the ED because they would "kill this guy." Subsequently, EMS contacted a transport helicopter and the patient was flown to another facility. Patient #10 presented to the ED with a "significantly elevated blood pressure" and exhibiting signs and symptoms of a stroke. The facility failed to implement their Acute Stroke Practice Standard for the Emergency Department; subsequently, Patient #10 did not receive medical imaging including a non-contrast head computed tomography (CT) scan until after being admitted to the medical/surgical floor and five (5) hours after arrival to the ED. Tour of the Emergency Department (ED) revealed the facility did not have a functioning telemetry monitor (shows the electrical activity of the heart) located at the nursing station, biohazard sharps containers or functioning pulse oximeters in the ED rooms, or adequate supplies to perform casting on fractured bones. In addition, the facility failed to ensure an overall institutional plan that included an annual operating budget was developed to ensure the facility had adequate supplies, equipment, and medications to adequately care for patients. The facility also failed to have a functioning Quality Assurance committee to identify and respond to quality deficiencies within the facility.	A 000		
A 043	GOVERNING BODY CFR(s): 482.12	A 043		

Signature: _____ Date: 3/4/19

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A 043	Continued From page 4 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on interview, record review, and review of facility policies and bylaws, it was determined the facility failed to have an effective governing body that was responsible for the conduct of the facility, and failed to ensure the facility had the financial means to operate effectively and protect the health and safety of patients. Observations and interviews conducted throughout the facility on 01/22-24/19 and 01/28-30/19 revealed the Chief Executive Officer (CEO) was aware the facility did not have adequate supplies and medications, but failed to provide oversight to ensure quality care was being provided. In addition, the facility failed to have an overall institutional plan that included an annual operating budget that included all anticipated income, expenses, and/or capital expenditures for a three-year period. Observations and interviews with staff revealed the facility failed to have adequate supplies, equipment, or medications to adequately care for patients due to budgetary constraints and the facility's inability to obtain cash flow to purchase needed items. The facility also had a debt with the Pharmacy Distributor of approximately one-half million dollars, and with their electronic medical records vendor of approximately six hundred thousand dollars, and all vendors supplying the facility were	A 043	The facility failed to have a functioning governing board and did not convene per policy. As members left, new members were not appointed. This led to an ineffective governing board, which could not hold the CEO accountable. Without an effective governing board and CEO there was no oversight of the QAPI plan and its implementation. No one was ensuring QAPI findings were presented to MEC, and QAPI meetings were being held weekly. The QAPI director resigned 7/2018, a physician sat on QAPI committee, attended meetings but had not been appointed. To correct the lack of a governing board, a list of potential candidates was drafted by hospital leadership and presented to the existing Governing Board which consisted of one person, Americore CEO. A new governing board was established and met on 2/22/19. The new governing board consist of three members, a general surgeon, a retired RN, and Americore CEO. A MEC meeting was held on 2/20/19 at which time the following physician committee chairpersons were appointed: QAPI committee, Utilization review/ Risk Management: Blood Utilization / Infection Control / Surgery; and, P & T / Dietary. Also appointed were Medical Directors of Surgery and Home Health. A QAPI plan was developed with new performance indicators for 2019. The QAPI plan was reviewed and approved by MEC on 2/20/19 and the new governing board as reflected in attached minutes. All QAPI activities will be reported through the QAPI committee weekly and then to MEC monthly, to the Medical staff bi- monthly and to the Governing Board monthly. See attached QAPI plan. The new Governing Board appointed a new CEO on 2/22/19 who will provide oversight to ensure quality care is being provided. This may be verified by board minutes. (CEO/Controller)	

Signature: _____ Date: 3/4/19

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

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A 043	Continued From page 5 now refusing to provide services and goods without upfront payments. Interviews with the facility's Chief Nursing Officer (CNO), Chief Financial Officer (CFO), and Chief Executive Officer (CEO) revealed the facility had no plan to ensure the facility could continue to operate. (Refer to A0057, A0073, A0115, A0145, A0263, A0273, A0385, A0395, A0489, A0490, A0799, A0837, A0940, A0951, A0955, A1100, A1103, and A1104.)	A 043	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC and sent to newly seated governing board for review and approval. This is verified by attached board minutes. See Attached minutes. **(Controller)** Because the governing board was not meeting monthly, it was not able to provide proper oversight. A policy was in place for meetings of the governing board but was not followed. The policy 200.103 Governing Board Responsibilities was revised for the governing board to meet monthly instead of twice annually to ensure better oversite for the facility. This policy revision was approved by MEC and the governing board. A calendar with meeting dates and times has been created by the Administrative Assistant and a copy attached. This will be verified by committee minutes and attendance log. Verified by minutes from the meeting. **(CEO)** Because the governing board was ineffective at holding the CEO accountable, MEC, QAPI and P&T committees were not meeting often enough to ensure proper implementation of the QAPI plan. The annual meeting calendar will be developed to ensure timely meetings by the necessary committees. This will be verified by committee attendance logs and minutes. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. **(Administrative Assistant)** The governing body failed to ensure that the facility had the financial means to operate effectively due to failing to have an institutional plan and annual operating budget, creating issues with adequate supplies, equipment, and medications. The controller presented an institutional plan, with an annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period to MEC, and it was sent and reviewed by the governing board. This is verified by attached board minutes. See Attached minutes. The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility staff was not always calling the materials management dept and	2/22/2019 2/22/2019 2/22/2019 3/5/2019

Signature: _____ Date: 3/4/19

asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ae replaced now through weekly orders to our materials supply vendor. The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and additional payment will be made to release order. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory, which is attached. The CEO was found to not be in compliance with overseeing the facility by ensuring that necessary equipment was in proper working order. The ED Central Cardiac Monitor has been repaired by DTG, initial payment submitted 2/11/2019 and final payment was submitted on 2/19/2019. Central monitor back in operation 3/1/2019. The nursing staff in the ED have been making rounds every 5-10 minutes for patients who requiring on going cardiac monitoring. Any patient who requires closer cardiac monitoring than q 5-10 minutes has a nurse 1 on 1. The ED is staff with 2 RN's or 1 RN and Paramedic 24/7. Due to not having EMR support we were not able to edit the computer software and perform regular updates. The support was restored 2/19/19 and an electronic reflex process was established to trigger dietary consults and social services consults. (CEO)

Signature: _____ Date: 3/4/19

A 057	CHIEF EXECUTIVE OFFICER CFR(s): 482.12(b) The governing body must appoint a chief executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Based on interview, record review, and review of facility policies and bylaws, it was determined the facility failed to have an effective governing body that was responsible for the conduct of the facility, and failed to ensure the facility had the financial means to operate effectively and protect the health and safety of patients. Observations and interviews conducted throughout the facility on 01/22-24/19 and 01/28-30/19 revealed the Chief Executive Officer (CEO) was aware the facility did not have adequate supplies and medications, and therefore was failing to provide goods and services necessary to care for patients. The findings include:	A 057	The facility failed to have a functioning governing board and did not convene per policy. As members left, new members were not appointed. This led to an ineffective governing board, which could not hold the CEO accountable. Without an effective governing board and CEO there was no oversight of the QAPI plan and its implementation. No one was ensuring QAPI findings were presented to MEC, and QAPI meetings were being held weekly. The QAPI director resigned 7/2018, a physician sat on QAPI committee, attended meetings but had not been appointed. To correct the lack of a governing board, a new governing board was established and met on 2/22/19. The new governing board consisting of three members, a general surgeon, a retired RN, and Americore CEO. A MEC meeting was held on 2/20/19 at which time the following physician committee chairpersons were appointed: QAPI committee, Utilization review/ Risk Management: Blood Utilization / Infection Control / Surgery; and, P & T / Dietary. Also appointed were Medical Directors of Surgery and Home Health. A QAPI plan was developed with new performance indicators for 2019. The QAPI plan was reviewed and approved by MEC on 2/20/19 and the new governing board as reflected in attached minutes. All QAPI activities will be reported through the QAPI committee weekly and then to MEC monthly, to the Medical staff bi- monthly and to the Governing Board monthly. See attached QAPI plan. The new Governing Board appointed a new CEO on 2/22/19 who will provide oversight to ensure quality care is being provided. This may be verified by board minutes. new board members were appointed by the existing board which consisted of one member. A new governing board was established and met 2/22/19. An interim QAPI director was appointed, and a QAPI meeting was held. A permanent QAPI physician director, Medical Director of Surgery, P&T physician director were appointed by MEC and approved by the new governing board, see attached minutes and attendance log. A QAPI plan was developed with new performance indicators for 2019. The plan for 2019 was reviewed and approved by MEC and the new governing board so oversite will be provided for quality care of the facility. MEC minutes were presented by Chief of Staff. Board minutes are attached. The new governing body appointed a new CEO on 2/22/19 who will provide oversight to ensure quality care is being provided. This may be verified by board minutes.	3/1/2019

Signature: M. M Date: 3/4/19

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SOUTHEASTERN KY MEDICAL CENTER	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

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A 057	Continued From page 6 Review of the facility policy titled "Governing Board Responsibilities," approved June 2017, revealed the governing board would meet at least twice annually and was responsible for the conduct of the facility consistent with the objectives of the facility and consistent with established standards of patient care. Review of Patient #1's medical record revealed the patient was admitted to the facility for abdominal pain on 08/16/18 and signed a consent on 08/16/18 to have an esophagogastroduodenoscopy (EGD); however, on 08/16/18 the facility performed a colonoscopy on the patient by mistake. Review of Patient #2's medical record revealed the facility admitted the patient on 10/10/18 with chest pain and to rule out a heart attack even though the facility did not have cardiology services available or an intensive care unit to monitor the patient. Further review of Patient #2's record revealed the facility failed to conduct heart testing, blood pressure monitoring, and laboratory testing to monitor the patient's cardiac status as ordered by the patient's physician. On 10/ 11/18 at 10:14 AM the patient developed a heart arrhythmia, but the facility failed to notify the patient's physician timely and Patient #2 was not transferred to an acute care facility for cardiac assessment and treatment until 10/11/18 at 6:00 PM, approximately thirty-four hours after the patient presented to the ED. Review of Patient #3's medical record revealed the patient presented to the facility's ED on 12/30/18 with severe left foot pain and review of the ED record revealed the patient's left foot and little toe were blue in color and cold. At 3:30 PM,	A 057	The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached. The CEO was found to not be in compliance with overseeing the facility by ensuring that necessary equipment was in proper working order, this was in part due to lack of funding needed to provide goods and services necessary to care for patients's. The ED tour revealed the facility did not have a functioning telementry monitor located at the nursing station and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. The ED did not have functional pulse oximeters, or have functional biohazard "sharps container", limited casting supplies and out dated casting supplies. To correct this issue the relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility staff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ae replaced now through weekly orders to our materiails supply vendor. The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed.The ED Central Cardiac Monitor has been repaired by DTG, initial payment submitted 2/11/2019 and final payment was submitted on 2/19/2019. Central monitor back in operation 3/1/2019. (CEO)	3/6/2019

Signature: _____ Date: 3/4/19

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

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A 057	Continued From page 7 the ED physician ordered Lovenox (used to prevent and treat blood clots) and Zosyn (antibiotic) to be administered to the patient; however, staff failed to administer Lovenox and Zosyn until 12/31/18, approximately twenty-four hours after the medication was ordered. Review of Patient #4's medical record revealed the patient was admitted for treatment of Congestive Heart Failure and Diabetes on 01/22/19. However, the facility failed to administer the patient's Insulin on 01/22/19 because it was not available. Further review of the medical record revealed the physician ordered on 01/23/19 to be notified when the patient's blood glucose was above 200. However the record revealed on 01/23/19 and 01/24/19, the physician was not notified when the patient's blood sugar was elevated above 200. Review of Patient #5's medical record revealed the patient presented to the ED with hip pain on 11/26/18; however, a hip X-ray was not obtained until 11/27/18. The x-ray revealed the patient's hip was fractured. However, the facility did not transfer the patient to obtain treatment for the fracture until 11/28/18. The facility also failed to provide tube feeding to Patient #5 while admitted to the facility from 11/26/18 through 11/28/18. In addition, the facility also failed to assess and treat wounds to the patient's leg and cigarette burns to the patient's fingers while being admitted to the facility from 11/26/18 through 11/28/18, and failed to administer the patient four (4) STAT medications on 11/26/18 until (two) 2 hours after the medications were ordered by the physician. Medical record review revealed the facility admitted Patient #7 to the facility on 01/06/19 with	A 057	The CEO was found to not be in compliance with overseeing the facility for stocking medications as indicated on the formulary. The CEO will oversee the director of pharmacy to ensure that the pharmacist will review the patient medication lists to look for medications that were not available will occur on a prospective basis. The list of these medications will be taken to the P&T Committee for evaluation to determine the need to add to the formulary or for a therapeutic substitution. (Newly appointed CEO) The facility was found to not be in compliance because the CEO did not ensure the conduct of the facility was in compliance. As a result, the facility did not ensure the staff were following proper procedure in obtaining the proper informed consent for patient #1 on 8/16/18. To prevent this issue from reoccurring, the CEO will oversee the CNO who will ensure the Surgery Charge Nurse, surgical staff and physicians are in-serviced on the Informed Consent policy, 700.223, and policy 700.003 on Verification of Correct Site, Correct Procedure and Correct Patient for Invasive or Surgical Procedures. This will be verified by the in-service attendance log. A new QAPI performance indicator has been added to the QAPI plan to monitor this measure. This will be verified by the in-service attendance log. (CEO) The CEO was found to not be in compliance with overseeing the CNO to ensure Policy and Procedures regarding medication administration were being followed. Patient's #3, #4, #5 (for STAT meds), and #7 did not receive the medication as ordered on time and no nursing documentation was present in support of reasons medications were given late. The CEO will oversee the CNO and verify that licensed nursing staff are in-serviced on policy 600.034, Medication Administration (pharmacy) and 700.707, Medication Administration (nursing) and on policy 200.421, Continum of Care to ensure nurses understanding of medication administration as ordered by physician and understanding importance of documenting in the patient's medical record. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. (CEO)	2/22/2019 and ongoing 3/1/2019 3/1/2019

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A 057	Continued From page 8 Cellulitis to the right lower extremity (skin infection), early sepsis (a potentially life-threatening condition caused by the body's response to an infection), and a Stage 2 pressure sore. However, the facility failed to administer the patient's Lovenox (medication to prevent blood clots) on 01/06/19 and it was not administered to the patient until 01/07/19, approximately twenty-two (22) hours after it was ordered by the physician and failed to ensure the patient's pressure sore was assessed/treated. Review of Patient #8's medical record revealed the patient was directly admitted to the medical surgical unit on 01/21/19 with signs and symptoms of stroke, even though the facility did not have a neurologist or speech/occupational/physical therapy services. In addition, the physician failed to transfer the patient to another facility for neurological assessment and care until 01/22/19 the day after admission. Review of Patient #10's medical record revealed Patient #10 presented to the ED on 11/12/18 with a "significantly elevated blood pressure" and exhibited signs and symptoms of a stroke. However, the patient did not receive medical imaging including a non-contrast head computed tomography (CT) scan until after being admitted to the medical/surgical floor and five (5) hours after arrival to the ED. Patient #10 was transferred to Facility #6 on 11/12/18 at 8:15 PM for treatment of an acute stroke. Review of Patient #11's medical record revealed the patient was admitted to surgical services on 09/21/18 at 9:40 PM for treatment of Gall Stones with pain, nausea, vomiting, etc., even though the	A 057	The CEO was found to not be in compliance with overseeing all departments to ensure a good working relationship throughout the facility. CEO will oversee department managers and verify all hospital staff will be in-serviced on 700.708, Interdepartmental Relationships. To implement this policy, department by department updates will be discussed at weekly Managers meetings to promote interdepartmental cohesiveness. The Administrative Assistant will add this meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee weekly. The CEO was found to not be in compliance with overseeing all departments to ensure a good working relationship throughout the facility. CEO will oversee department managers and verify all hospital staff will be in-serviced on 700.708, Interdepartmental Relationships. To implement this policy, department by department updates will be discussed at weekly Managers meetings to promote interdepartmental cohesiveness. The Administrative Assistant will add this meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (CEO) The CEO failed to oversee the CNO to ensure that a process was in place for the notification for dietary consults be performed. HIM Director put in place a new electronic reflex process to trigger automatic notification to dietary for a consult. The reflex is attached to a question on flowchart and when nursing staff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dietician of the consult. CEO will oversee and verify that dietary and nursing services will be in-serviced on the electronic reflex process. A Registered Dietician was hired 2/22/19. Diet orders were reviewed and verified by the RD on 2/22/19. A test patient was used to verify that the reflex process for Dietary Consultants would work. (HIM Director) The CEO failed to oversee the CNO to ensure that the facility's nursing service would follow policy. The nursing service failed to report and follow up on medication errors was identified in the survey findings. Nursing Service will be in-serviced on the Medication Error Policy, 600.085 and to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and MEC. This will be verified by the in-service attendance log. CEO will oversee and verify that licensed nursing staff will be in-serviced on policy 600.085. Medication Error. (CEO)	3/1/2019 2/22/2019 3/1/2019

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A 057	Continued From page 9 ED physician was "uncertain if anesthesia was available." The consulting Gastrointestinal Physician saw Patient #11 on 09/21/18 and his recommendations were to transfer the patient "where they can do surgery." However, the facility failed to transfer Patient #11 for treatment until 09/24/18, three days later. Review of Patient #12's medical record revealed Patient #12 presented to the Emergency Department (ED) in full cardiac arrest on 12/04/18. On two different occasions the patient required multiple doses of Epinephrine (a medication to stimulate the heart) in an effort to sustain the patient's life. However, the facility failed to have enough Epinepherine to treat the patient, and Epinepherine had to be supplied to the facility by the Emergency Medical Services (EMS) that had transported the patient to the ED. Interview with the Emergency Medical Director on 01/29/19 at 2:45 PM, revealed on 07/17/18, EMS was attempting to transfer an unknown patient to the ED who was exhibiting signs and symptoms of an acute stroke. However, when EMS contacted the ED to inform them that they were en route with the patient, they were informed by RN #11 not to bring the patient to the ED because they would "kill this guy." Subsequently, EMS contacted a transport helicopter and the patient was flown to another facility. The facility failed to have a system for consulting the Registered Dietitian (RD) when patients had feeding tubes, pressure ulcers/wounds, or Diabetes, and failed to have an effective system to ensure patients received physician ordered diets.	A 057	The CEO failed to oversee the CNO to ensure that the facility's nursing service would follow policy. The nursing service failed to monitor and notify patient's physician of change of status. Licensed nursing staff will be in-serviced on policy 200.403, Assessment and Reassessment of the patient. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. This will be verified by way of an in-service attendance log. The facility's nursing service failed to consult the RD and notify the physician when a patient's skin integrity was compromised. Licensed nursing staff will be in-serviced on policy 200.420, Skin Integrity. Chart audits will be performed daily by nursing staff to ensure compliance. This will be verified by way of an in-service attendance log. (CEO) The CEO failed to ensure that the facility integrate the ED with other departments of the facility. Policy 700.709, MedSurg-Scope of Care was revised by MEC on 2/20/2019 and approved by the new board on 2/22/19 to better define the scope of services, and to better integrate the ED with the rest of the facility. This will be done by in-servicing clinical staff on the MedSurg-Scope of Care policy, 700.709. The CEO will oversee and verify that the staff is in-serviced, this will be verified by in-service attendance log. (CEO) The CEO will be responsible to ensure adequate resources are available, assigning adequate number of staff allowing staff sufficient time to participate in QAPI activities and instituting appropriate information systems for collecting and analyzing data. The CEO will report any and all findings to the governing body. (CEO) The requirement for the Governing Board, MEC, QAPI and P&T committees to meet on a set schedule was not met. The annual meeting calendar will be developed to ensure timely meetings by the necessary committees. This will be verified by committee attendance logs and minutes. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (Administrative Assistant)	3/1/2019 3/1/2019 3/1/2019 2/22/2019

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A 057	Continued From page 10 Tour of the Emergency Department (ED) on 01/23/19 9:45 AM and 1/30/19 at 5:15 PM revealed the facility did not have a functioning telemetry monitor (shows the electrical activity of the heart) located at the nursing station, and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. Further observations revealed eight (8) of nine (9) rooms in the ED did not have a functional pulse oximeter (a device used to measures the amount of oxygen in the blood). Observations in the ED also revealed none of the nine (9) ED rooms contained a functional biohazard "sharps" container. Observations on 1/30/19 at 5:15 PM revealed ED staff had to transport used needles and devices through the hallway to get to a biohazard container to dispose of the items. In addition, observation of the casting room revealed it contained a limited number of supplies necessary to cast fractured bones of patients presenting to the ED in need of casting services. The ED's entire supply of casting tape was expired and the appropriate sizes were not available to treat various injuries. Observations of the Surgical Department on 01/23/ at 10:50 AM revealed the department's surgical disinfectant solutions that they were currently utilizing to clean and disinfect the surgical rooms and surgical instruments (VirexTB and Envy) had expired in 2018. Interviews on 01/23/19 at 10:55 AM with Sterile Processing Technician #1 and at 11:00 AM with Sterile processing Technician #2 revealed during a period in December 2018 (exact date unknown) no instruments could be sterilized due to no biologics being available. Interview with Physician #9 on 01/30/19 at 11:00 AM revealed he stopped practicing at the facility in October	A 057	Due to not having EMR support we were not able to edit the computer software and perform regular updates. The support was restored 2/19/19 and an eletronic reflex process has now been set for dietary consults and social services. The reflex is attached to questions on the flowchart and when nursing staff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dietician of the consult. A reflex was also attached to questions in flowchart pertaining to social services. When nursing staff choose answers to questions, it sends an electronic trigger to social services department and staff. A test patient is in the system and and both dietary and social services consults have been performed with both departs receiving the referral. (CEO)	2/22/2019

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A 057	Continued From page 11 2018 because continuing to provide care in the facility was endangering the lives of his patients. The physician stated there was not adequate equipment or supplies in the surgery department, there had been times when instruments could not be sterilized, and staff has had to leave in the middle of a surgical procedure to search the facility for needed supplies. Interview with the Director of Pharmacy on 01/23/19 at 2:45 PM revealed the facility had only one (1) Activase (used to treat blood clots in patients having heart attacks and strokes) in the entire building and she had informed the facility's physicians of this situation. The Director of Pharmacy stated the reason for the lack of medications was the cost. The Director of Pharmacy stated the facility owed around half a million dollars to the drug distributor for the facility and could not order any more medications without paying up front. Continued interview revealed that there are some medications in the pharmacy that have expired that the facility cannot replace them due to the cost. Continued interview with the Director of Pharmacy revealed she had emailed the CEO and the medication distribution vendor and the vendor referred her to their legal department. The Director of Pharmacy stated she was filling the crash carts with the last of the Vasopressin, Verapamil, EPI, Nitroglycerin 50/250ml, and Sodium Bicarbonate 8.4%50 ml and she would have no ability to obtain anymore. The Director of Pharmacy stated to sign up with another medication distribution vendor would take eight (8) weeks or more and the CEO's plan was to "borrow" medication from a facility that he was attempting to purchase on 02/01/19 in Missouri. The Director of Pharmacy was questioning the surveyors regarding the legalities of this	A 057	The facility failed to have a functioning governing board, therefore the facility had no institutional plan or annual operating budget in place. The facility was also found to not have a policy or procedure related to the development of a budget. An institutional plan, including annual operating budget including all anticipated income, expenses, and capital expenditures for a three-year period has been created. This plan was presented to MEC and sent to newly seated governing board for review and approval. This is verified by attached board minutes. See Attached minutes. Policy Budget Policy was developed. The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory, which is attached. Due to no institutional plan and budget being in place the facility failed to ensure that necessary equipment was in place and in proper working order. This also, includes, the cardiac monitor for the ED, material supplies throughout the facility, the EMR system, and payroll. The ED Central Cardiac Monitor has been repaired by DTG, Central monitor back in operation 3/1/2019. EMR support was restored on 2/19/19 so regular software updates are now being performed. The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility staff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ae replaced now through weekly orders to our materials supply vendor. (CEO/Controller)	3/6/2019

Signature: _____ Date: 2/21/19

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A 057	Continued From page 12 "scheme." Review of the last Governing Board Meeting Minutes conducted by the facility dated 08/21/18, revealed the meeting was a virtual meeting and three (3) members were present. The Governing Body made recommendations to approve temporary privileges for eight (8) physicians, approved the privileges of the former administration's medical staff for six (6) months, and adopted the former administration's bylaws, rules/regulations, and policies/procedures. Further review of the meeting minutes revealed no other discussions took place or no further actions taken. Interview with a Former Governing Body Member on 01/30/19 at 2:07 PM, revealed that she was no longer employed by the facility's corporation and no longer functioned as a governing body member as of "last week." The Former Member stated that the Chief Executive Officer (CEO) was responsible for "ninety percent" of oversight provided to the facility, and had daily communication with the Chief Nursing Officer (CNO) and the Chief Financial Officer (CFO) who are at the facility. The Former Member stated that the Governing Body only met "sporadically and not consistently." The Former Member was unable to state when the last governing body meeting was held for the facility or what members besides herself had made up the governing body. The Former Member stated that there was constant conversation about the facility's finances, and that the cash flow of the facility was always the topic of priority. The Former Member stated that she was not aware of a meeting or conversation she had attended or participated in regarding the facility that was not dominated by	A 057		

Signature: _____ Date: 2/1/19

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A 057	Continued From page 13 finances. The Former Member stated she was never involved in or aware of care concerns at the facility. Interview on 01/30/19 at 2:38 PM with the CEO and Owner of the facility revealed the CNO and CFO function as the onsite administration at the facility, and are responsible for the day to day operations. The CEO stated he provided oversight by talking via telephone to the CNO and CFO several times a day. The CEO stated that he and two other members comprise the governing body of the facility, but was unable to state who the other two members were. The CEO was unable to state how often the governing body met or provide any structural details of the meetings. The CEO was unable to say what was routinely discussed in the governing body meetings or when the last meeting had occurred. The CEO stated the governing body had never been informed or discussed any adverse events that had occurred at the facility. (Refer to A0043, A0073, A0115, A0145, A0263, A0273, A0385, A0395, A0489, A0490, A0799, A0837, A0940, A0951, A0955, A1100, A1103, and A1104.)	A 057		
A 073	INSTITUTIONAL PLAN AND BUDGET CFR(s): 482.12(d) The institution must have an overall institutional plan that meets the following conditions: (1) The plan must include an annual operating budget that is prepared according to generally accepted accounting principles. (2) The budget must include all anticipated income and expenses. This provision does not require that the budget identify item by item the	A 073		

Signature: _____ Date: 3/4/19

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A 073	Continued From page 14 components of each anticipated income or expense. (3) The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph (d)(2) of this section is applicable. (4) The plan must include and identify in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following: (i) Acquisition of land; (ii) Improvement of land, buildings, and equipment; or (iii) The replacement, modernization, and expansion of buildings and equipment. This STANDARD is not met as evidenced by: Based on record review and interview it was determined the facility failed to have an overall institutional plan with an annual operating budget that included all anticipated income and expenses, and contained capital expenditures for a three-year period. Observations and interviews with staff revealed the facility failed to have adequate supplies, equipment, or medications to adequately care for patients due to budgetary constraints and the facility's inability to obtain cash flow to purchase needed items. The facility owes their supplying pharmacy approximately one-half million dollars, and their electronic medical records vendor approximately six hundred thousand dollars, and all vendors supplying the facility are now refusing to provide services and goods without prepayment payments.	A 073	The facility failed to have a functioning governing board, therefore the facility had no institutional plan or annual operating budget in place. The facility was also found to not have a policy or procedure related to the development of a budget. An institutional plan, including annual operating budget including all anticipated income, expenses, and capital expenditures for a three-year period has been created. This plan was presented to MEC and sent to newly seated governing board for review and approval. This is verified by attached board minutes. See Attached minutes. Policy Budget Policy was developed. The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory, which is attached. Due to no institutional plan and budget being in place the facility failed to ensure that necessary equipment was in place and in proper working order. This also, includes, the cardiac monitor for the ED, material supplies throughout the facility, the EMR system, and payroll. The ED Central Cardiac Monitor has been repaired by DTG. Central monitor back in operation 3/1/2019. EMR support was restored on 2/19/19 so regular software updates are now being performed. The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility staff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ae replaced now through weekly orders to our materials supply vendor. (CEO/Controller)	3/6/2019

Signature: _____ Date: 3/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

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A 073	Continued From page 15 Interviews with the facility's Chief Nursing Officer (CNO), Chief Financial Officer (CFO), and Chief Executive Officer (CEO) revealed the facility had no plan to ensure the facility could continue to operate. The findings include: Interview with the facility's CFO on 01/28/19 at 6:00 PM, revealed the facility did not have a policy or procedure related to the development of a budget. Review of the facility's "Operating Budget for the Period Ending June 30, 2019" revealed the facility had projected total net revenue of 927, 110 dollars for each month from July 2018 through December 2018. Further review revealed the facility had projected total operating expenses of 1,175,517 dollars for each month from July 2018 through December 2018. Therefore, the facility had a projected net operating loss of 248,407 dollars for each month from July 2018 through December 2018. Further review of the Operating Budget revealed for January 2019 the facility had a projected net revenue of 1,012,460 dollars and projected total operating expenses of 1,087,033 dollars. For February 2019, the facility had a projected net revenue of 1,046,577 dollars, and projected total operating expenses of 1,019,404 dollars. For March 2019, the facility had a projected net revenue of 1,082,401 dollars and projected total operating expenses of 958,539 dollars. For April 2019, the facility had a projected net revenue of 1,120,016 dollars, and projected total operating expenses of 903,760 dollars. Continued review for May 2019 revealed the facility had a projected	A 073		

Signature: _____ Date: 3/11/19

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 073	Continued From page 16 net revenue of 1,159,512 dollars and projected total operating expenses of 903,760 dollars, and for June 2019 the facility had a projected net revenue of 1,200,982 dollars and projected of total operating expenses of 903,760 dollars. Continued review of the facility's Operating Budget revealed for the fiscal year of July 2018 through June 2019, the facility projected a loss of 644,748 dollars. The facility was unable to provide a three-year plan for capital expenditures. Observations made throughout the facility on 01/22-24/19 and 01/28-30/19 revealed the facility was operating with a Medical/Surgical Floor, Emergency Department, and Surgical Department. Continued observations revealed the facility had a lack of necessary supplies in all areas to ensure patients received adequate care and services. Observations and interviews from 01/22-24/19 and 01/28-30/19 revealed on the medical surgical unit, staff were limited to how much linen they could utilize for patients due to linen delivery being cut back to once per month; patients did not have ordered medications because they were not available from the pharmacy. Interview with Physician #5 on 01/29/19 at 4:30 PM revealed he was instructing patients to bring medications from home to be administered to them while they were admitted to the facility. Observations in the Emergency Department on 01/23/19 at 9:45 AM and 01/30/19 at 5:15 PM, revealed the facility did not have a functioning telemetry monitor (shows the electrical activity of	A 073		

Signature: _____ Date: 3/4/19

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A 073	Continued From page 17 the heart) located at the nursing station, and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room; eight (8) of nine (9) rooms in the ED did not have a functional pulse oximeter (a device used to measures the amount of oxygen in the blood); none of the nine (9) ED rooms contained a functional biohazard "sharps" container; and the ED's entire supply of casting tape was expired and the appropriate sizes were not available to treat various injuries. Observations of the Surgical Department on 01/23/19 at 10:50 AM revealed the department's supply of surgical disinfectant solutions (Virex TB and Envy)that the staff was currently utilizing to clean and disinfect the surgical rooms and surgical instruments had expired in 2018. Interviews on 01/23/19 at 10:55 AM with Sterile Processing Technician #1 and at 11:00 AM with Sterile Processing Technician #2 revealed during a period in December 2018 (exact unknown) no instruments could be sterilized due to no biologics being available. Interview with Physician #9 01/30/19 at 11:00 AM revealed he stopped practicing at the facility in October 2018, because continuing to provide care in the facility was endangering the lives of his patients. The physician stated there was not adequate equipment or supplies in the Surgery Department, there had been times when instruments could not be sterilized, and staff has had to leave in the middle of a surgical procedure to search the facility for needed supplies. Interviews on 01/22/19, with the CNO at 12:00 PM, and the ACNO at 12:30 PM, revealed they were aware that the facility had an overall lack of supplies and was unable to obtain medications	A 073		

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A 073	Continued From page 18	A 073		

for administration to patients due to a lack of funds to pay for the services. The CNO and ACNO stated any vendor currently contracted with the facility would not provide services unless payment was received in advance, and with no funds available, services could not be paid for. The CNO stated she talked daily with the CFO and did not know of any solutions to the facility's current financial problems. The CNO stated her primary goal on a day to day basis was to ensure patients received adequate care in the facility. However, the CNO stated that was becoming more and more difficult to do each day. In addition, the CNO and ACNO stated the facility had been unable to meet payroll for facility staff consistently since the current CEO had taken over the facility in May of 2018. In addition the CNO stated that employees had been having health insurance premiums deducted from their paychecks by the facility; however, the facility had not been paying the insurance premiums and the staff was without coverage. The administrators went on to say that direct care staff planned to "walk out" of the facility the next time they did not receive a paycheck timely.

Interview with the facility's CFO on 01/28/19 at 6:00 PM revealed he was responsible for the day to finances at the facility, and had been since the current CEO had acquired the facility in May of 2018. He stated he was in contact with the Chief Executive Officer (CEO) daily. The CFO stated the numbers utilized for the Operating Budget came from the CEO, and the CFO was unable to explain why the facility's total net revenue and net operating income had remained exactly the same for July 2018 through December 2018. In addition, the CFO was unable to explain why the facility did not have a three-year budget plan as

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A 073	Continued From page 19 required. The CFO stated that his main priority at the facility was to manage day to day expenses and attempt to obtain the most critical services and inventory needed to fund the facility and keep it running. The CFO stated that the facility had no viable plan to make up the facility losses nor plans on paying overdue expenditures, such as the facility's pharmacy supplier who was owed approximately "one-half million dollars" or the approximately "six hundred thousand dollars" the facility owed the medical records vendor. Continued interview with the CFO revealed the physical building comprising the facility was currently being "litigated in Federal Bankruptcy Court, and the CEO was attempting to purchase the building." However, "there was opposition to the acquisition"; therefore, "there was no way to gain capital from the physical building such as through a loan or mortgage." Interview with a Former Governing Body Member on 01/30/19 at 2:07 PM, revealed she was no longer employed by the facility's corporation and no longer functioned as a governing body member as of "last week." The Former Member stated the Chief Executive Officer (CEO) and the Chief Financial Officer (CFO) spoke daily related to the facility's finances. The Former Member stated the facility has significant financial constraints. The Former Member stated that the most urgent problem at the facility as of last week was "cash flow coming through the door." The Former Member stated that she was unsure of the facility's specific budget plans but knew that the facility was expecting the 2018 cost report to return a high settlement back to the hospital. The Former Member stated that she unaware if the facility had developed a "formalized" budget since the acquisition of the facility had occurred	A 073		

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A 073	Continued From page 20 approximately six (6) months ago. Interview on 01/30/19 at 2:38 PM with the Chief Executive Officer (CEO) and Owner of the facility revealed the facility was in a "turnaround mode" and he was constantly looking for ways to "turn the hospital around." The CEO stated the most important objective at this point was to find a way to stabilize the facility's financial position. The CEO stated he believed that as of now the financial point of view of the hospital was "not that bad." The CEO stated the facility had changed billing companies in October 2018, and the contracted company had done a "terrible job" and the facility's collections "have fallen off a cliff." The CEO stated the facility was in the process of hiring a different collection company, and was hoping to stabilize and grow the hospital. The CEO stated that he was unaware of the facility's specific budget, stating that would be the responsibility of the CFO. (Refer to A0043, A0057, A0115, A0145, A0263, A0273, A0385, A0395, A0489, A0490, A0799, A0837, A0940, A0951, A0955, A1100, A1103, and A1104.)	A 073		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview, record review, review of the facility's Abuse/Neglect policy, and review of medical records from Facilities #2, #3, and #4, it was determined the facility failed to protect the rights of six (6) of twelve (12) patients.	A 115		

Signature: _____ Date: 3/4/19

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A 115	Continued From page 21 Observations revealed the facility provided Emergency Department (ED) services, and Surgical Services (services were limited to general surgery), and had a twelve (12) bed medical surgical inpatient unit. Interviews revealed the facility did not provide intensive/critical care services and had no policy/procedure in place regarding the scope of services that the medical surgical unit could provide. Subsequently, the facility admitted Patients #2, #8, and #11 for treatment of diagnoses that the facility could not provide. Patient #2 was admitted with chest pain and to rule out a heart attack even though the facility did not have cardiology services available or an intensive care unit to monitor the patient. The facility failed to conduct heart testing, blood pressure monitoring, and laboratory testing to monitor the patient's cardiac status as ordered by the patient's physician. When the patient developed a heart arrhythmia, the facility failed to notify the patient's physician timely, and Patient #2 was not transferred to an acute care facility for cardiac assessment and treatment until approximately 34 (thirty-four) hours after the patient presented to the ED and developed chest pain. Patient #8 was directly admitted to the medical surgical unit with signs and symptoms of a stroke, even though the facility did not have a neurologist or speech/occupational/physical therapy services. The facility failed to administer medications to the patient for treatment of high blood pressure/chest pain, and chronic kidney disease. Interviews revealed staff notified the patient's physician that the patient was having stroke symptoms; however, the physician failed to transfer the patient to another facility for neurological	A 115	The facility had no effective process in place to protect and promote each patient's rights. Twelve patient charts were reviewed and the facility failed to protect the rights of six of the patients from neglect. No intensive/critical care services were available at the facility, no policy and procedure in place integrate the ED with other departments of the facility and no policy and procedure in place to define the scope of services for the medical surgical unit. Patient's #2, #8, and #11 were admitted for treatment of diagnoses the facility could not treat. The physician was not notified timely when there was a change in status for the patient or when medications were not administered timely, and no process in place to ensure timely transfers of patients when the patients required services not available at the facility. Policy 700.315 ER Scope of Care, and Policy 700.709 MedSurg Scope of Care were revised and approved by MEC on 2/20/2019 and the approved by the new board on 2/22/19 to better define all scope of services. This was done to better integrate the ED with the rest of the facility and better define the scope of services for the medical surgical unit. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 200.201 Patients Rights, policy 600.034 Medication Administration (Pharmacy) and 700.707 Medication Administration (Nursing), policy 200.421 Continuum of Care, policy 200.403 Assessment and Reassessment of patients, 200.603 Transfer of Patients and on policy 700.240 Physician Orders. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. A procedure to ensure compliance with the policy has been put into place so that the charge nurse/supervisor will evaluate each patient prior to admission to see if it meets acceptable admission criteria according to scope of services policy. (CEO, CNO)	2/22/2019

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A 115	Continued From page 22 assessment and care until the day after admission. According to the nurse, the physician stated, "Don't call me back anymore. We'll sit on it tonight and transfer [him/her] out tomorrow." The facility admitted Patient #11 to Surgical Services on 09/21/18 for treatment of Gall Stones with pain, nausea, vomiting, etc., even though the ED physician was "uncertain if anesthesia was available." The consulting Gastrointestinal Physician saw Patient #11 on 09/21/18, and his recommendations were to transfer the patient "where they can do surgery." However, the facility failed to transfer Patient #11 for treatment until 09/24/18, three days later. In addition, Patient #5 presented to the facility's Emergency Department (ED) on 11/26/18 with hip pain. The facility failed to obtain a hip x-ray until after the patient was admitted on 11/27/18. The x-ray revealed the patient's hip was fractured; however, the facility did not transfer the patient to obtain treatment for the fracture until 11/28/18. In addition, the patient had physician orders for a regular diet; however, the patient had a feeding tube due to swallowing issues and could not consume a diet by mouth. The facility failed to contact the physician or the Registered Dietitian to ensure the patient received appropriate nourishment and the patient received no tube feeding while at the facility for approximately two days. Further, the facility failed to assess and treat wounds to the patient's leg and cigarette burns to the patient's fingers and failed to administer medications to the patient as ordered by the physician. Patient #3 presented to the facility ED on 12/30/18 at 2:35 PM with severe left foot pain and	A 115	The facility had no effective process in place to protect and promote each patient's rights. Twelve patient charts were reviewed and the facility failed to protect the rights of six of the patients from neglect. For patient #5, the facility failed to contact the physician or RD to ensure the patient received appropriate nourishment, failed to assess and treat wounds, failed to administer medications to the patient as ordered by the physician, and failed to transfer patient timely. An electronic reflex process was put in place. The reflex is attached to questions on the flowchart and when nursing staff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dietician of the consult. A registered dietian (RD) was hired on 2/22/19. Diet orders were reviewed and verified by the RD. The reflex process was tested and verified during the 2/22/19 visit. Nursing services will be in-serviced on 200.421 Continuum of Care, 200.420 Skin Assessment, 600.034 Medication Administration (Pharmacy), 700.707 Medication Administration (Nursing) and 200.603 Transfer of Patients. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO)	3/1/2019

Signature: _____ Date: 3/4/19

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A 115	Continued From page 23 the patient's left foot and little toe were blue in color and cold. At 3:30 PM, the ED physician ordered Lovenox (used to prevent and treat blood clots), Zosyn (antibiotic), and Demerol (medication to treat pain); however, staff failed to administer Lovenox and Zosyn until the next day, approximately twenty-four hours after the medication was ordered. In addition, at 4:13 PM, testing confirmed the patient had a blood clot in an artery in the leg that was blocking blood flow. However, the facility admitted the patient to the facility and did not transfer Patient #3 to a facility that could treat the blood clot until 01/01/19 at 12:00 PM. The facility admitted Patient #4 for treatment of Congestive Heart Failure and Diabetes but failed to administer the patient's Insulin because it was not available at the facility. Then, when the patient's blood sugar was high, the facility failed to notify the patient's physician as ordered of the elevated blood sugars.	A 115	The facility had no effective process in place to protect and promote each patient's rights. Twelve patient charts were reviewed and the facility failed to protect the rights of six of the patients from neglect. For patient #3 the facility's staff failed to administer medication on time as ordered by physician, failed to contact the physician and failed to transfer patient timely. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 200.201 Patient Rights, policy 600.034 Medication Administration (pharmacy) and 700.707 Medication Administration (nursing), on policy 200.421 Continuum of Care, on policy 200.403 Assessment and Reassessment of patients, 200.603 Transfer of Patients and on policy 700.240 Physician Orders. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO) The facility had no effective process in place to protect and promote each patient's rights. Twelve patient charts were reviewed, and the facility failed to protect the rights of six of the patients from neglect. For patient #4 the facility failed to administer a medication due to unavailability and failed to notify the physician as ordered. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 600.098 Drug Product Selection - Formulary, policy 200.403 Assessment and Reassessment of patients, policy 600.034 Medication Administration (pharmacy), 700.707 Medication Administration (nursing) and on policy 700.240 Physician Orders. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medication will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board (CEO)	3/1/2019 3/1/2019

Signature: _____ Date: 3/4/19

		A115		3/1/2019
			In-service education related to proper nursing documentation will be provided by Nurse Educator from Lincoln Memorial University. This will be verified by way of the in-service attendance log. (CNO)	3/1/2019
			The reporting and follow up on medication errors was identified in the survey findings. The Medication Error Policy 600.085 has been in-serviced to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and MEC. This will be verified by the in-service attendance log. Licensed nursing staff will be in-serviced on policy 600.085, Medication Error. This will be verified by way of the in-service attendance log. (ACNO)	3/1/2019
			Licensed nursing staff will be in-serviced on policy 200.407 Identifying and Reporting Victims of Abuse and Neglect. This will be verified by way of the in-service attendance log (ACNO)	

Signature: _____ Date: 3/1/19

A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on observation, interview, record review, review of the facility's Abuse/Neglect policy, and review of medical records from Facilities #2, #3, and #4 revealed the facility failed to protect six (6) of ten (10) patients from neglect. Observations revealed the facility provided Emergency Department (ED) services, and	A 145	The facility had no effective process in place to keep the patient free from all forms of abuse and harrassment. Ten patient charts were reviewed and the facility failed to protect the rights of six of the patients. For patient #2 the facility's staff failed to contact and document the physician when orders were not carried out, failed to notify the physcian regarding change in patient status and failed to transfer patient timely. No intensive/critical care services were available at the facility, no policy and procedure in place to integrate the ED with other departments of the facility and no policy and procedure in place to define the scope of services for the medical surgical unit. Policy 200.201 Patient Rights, policy 700.315 ER Scope of Care, and Policy 700.709 MedSurg Scope of Care were revised and approved by MEC on 2/20/2019 and the approved by the new board on 2/22/19 to better define all scope of services. This was done to better integrate the ED with the rest of the facility and better define the scope of services for the medical surgical unit. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 200.421 Continuum of Care, on policy 200.403 Assessment and Reassessment of patients, 200.603 Transfer of Patients and on policy 700.240 Physician Orders. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO)	3/1/2019

Signature: _____ Date: 3/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN KY MEDICAL CENTER	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

(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) COMPLETION DATE
A 145	Continued From page 24 surgical services (services were limited to general surgery), and had a twelve (12) bed medical surgical inpatient unit. Interviews revealed the facility did not provide intensive/critical care services and had no policy/procedure in place regarding the scope of services that the medical surgical unit could provide. Subsequently, the facility admitted Patients #2, #8, and #11 for treatment of diagnoses that the facility could not provide. Patient #2 was admitted with chest pain and to rule out a heart attack even though the facility did not have cardiology services available or an intensive care unit to monitor the patient. The facility failed to conduct heart testing, blood pressure monitoring, and laboratory testing to monitor the patient's cardiac status as ordered by the patient's physician. When the patient developed a heart arrhythmia, the facility failed to notify the patient's physician timely and Patient #2 was not transferred to an acute care facility for cardiac assessment and treatment until approximately thirty-four (34) hours after the patient presented to the ED and developed chest pain. Patient #8 was directly admitted to the medical surgical unit with signs and symptoms of stroke, even though the facility did not have a neurologist or speech/occupational/physical therapy services. The facility failed to follow their stroke protocol and the patient did not receive a Computerized Tomography (CT) scan for approximately one hour after arrival. In addition, the facility failed to administer medications to the patient for treatment of high blood pressure/chest pain, and chronic kidney disease. Interviews revealed staff notified the patient's physician that the patient was having stroke symptoms and the patient's CT	A 145	The facility had no effective process in place to keep the patient free from all forms of abuse and harrassment. Ten patient charts were reviewed and the facility failed to protect the rights of six of the patients. For patient #8 the facility directly admitted a patient to the Medical Surgical unit that the facility was unable to care for. The facility also failed to follow the Stroke Protocol on the MedSurg unit therefore a necessary test was not completed timely. A medication was not administered to the patient. The physician failed to transfer that patient timely. Policy 200.201 Patient Rights, policy 700.709 MedSurg Scope of Care was revised and approved by MEC on 2/20/2019 and the approved by the new board on 2/22/19 to better define all scope of services. A procedure has been put into place for the charge/supervisor nurse to screen the direct admit patients to determine if the patient can be admitted based upon the scope of services. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on Policy 200.201 Patient Rights policy 700.709 MedSurg Scope of Care, policy 700.321 Stroke Protocol, policy 600.034 Medication Administration (Pharmacy) and 700.707 Medication Administration (Nursing), policy 700.240 Physician Orders, policy 200.603 Transfer of Patients. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO) The facility had no effective process in place to keep the patient free from all forms of abuse and harassment. Ten patient charts were reviewed and the facility failed to protect the rights of six of the patients. For patient #11 the facility failed to transfer the patient timely. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 200.603 Transfer of Patients. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new	3/1/2019 3/1/2019

Signature: _____ Date: 3/1/19

Governing Board. (CEO)

Signature: _____ Date: 3/4/19

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A 145	Continued From page 25 scan was a "suboptimal study due to movement artifacts;" however, the physician failed to transfer the patient to another facility for neurological assessment and care until the day after admission. According to the nurse, the physician stated, "Don't call me back anymore. We'll sit on it tonight and transfer [him/her] out tomorrow." The facility admitted Patient #11 to Surgical Services on 09/21/18 for treatment of Gall Stones with pain, nausea, vomiting, etc. even though the ED physician was "uncertain if anesthesia was available." The consulting Gastrointestinal Physician saw Patient #11 on 09/21/18, and his recommendations were to transfer the patient "where they can do surgery." However, the facility failed to transfer Patient #11 for treatment until 09/24/18, three days later. In addition, Patient #5 presented to the ED with hip pain on 11/26/18; however, a hip x-ray was not obtained until 11/27/18. The x-ray revealed the patient's hip was fractured; however, the facility did not transfer the patient to obtain treatment for the fracture until 11/28/18. In addition, Patient #5 had physician orders for a regular diet; however, the patient had a feeding tube due to swallowing issues and could not consume a diet by mouth. The facility failed to contact the physician or the Registered Dietitian to ensure the patient received appropriate nourishment and the patient received no tube feeding while the patient was at the facility for approximately two (2) days. Further, the facility failed to assess and treat wounds to the patient's leg and cigarette burns to his/her fingers and failed to administer medications to the patient as ordered by the physician.	A 145	The facility had no effective process in place to keep the patient free from all forms of abuse and harrassment. Ten patient charts were reviewed and the facility failed to protect the rights of six of the patients. For patient #5, the facility failed to contact the physician or RD to ensure the patient received appropriate nourishment, failed to complete physican orders, failed to assess and treat wounds, failed to administer medications to the patient as ordered by the physician, failed to have a needed supply on hand, and failed to transfer patient timely. The reflex is attached to questions on the flowchart and when nursing staff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dietician of the consult. A registered dietian (RD) was hired on 2/22/19. Diet orders were reviewed and verified by the RD. An electronic reflex process was put in place. The reflex process was tested and verified during the 2/22/19 visit. Nursing services will be in-serviced on Policy 200.201 Patient Rights, policy 200.421 Continuum of Care, 200.420 Skin Assessment, 600.034 Medication Administration (Pharmacy), 700.707 Medication Administration (Nursing), policy 200.403 Assessment and Reassessment of patients, 200.603 Transfer of Patients, 700.240 Physician's Orders and policy 200.207 Chain of Command for Resolution of Clinical Issues. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO)	3/1/2019

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A 145	Continued From page 26 Patient #3 presented to the facility's ED on 12/30/18 at 2:35 PM with severe left foot pain and the patient's left foot and little toe were blue in color and cold. At 3:30 PM, the ED physician ordered Lovenox (used to prevent and treat blood clots), Zosyn (antibiotic), and Demerol (medication to treat pain); however, staff failed to administer Lovenox and Zosyn until the next day, approximately twenty-four hours after the medication was ordered. In addition, at 4:13 PM, testing confirmed the patient had a blood clot in an artery in the leg that was blocking blood flow. However, the facility admitted the patient to the facility and did not transfer Patient #3 to a facility that could treat the blood clot until 01/01/19 at 12:00 PM. Further, the facility admitted Patient #4 for treatment of Congestive Heart Failure and Diabetes. However, the facility failed to administer the patient's Insulin because it was not available at the facility. Then, when the patient's blood sugar was high, the facility failed to notify the patient's physician as ordered of the elevated blood sugars. The findings include: Review of the facility's "Patient Abuse or Neglect" policy, approved June 2017, revealed "Patient abuse and neglect is defined as any incident of physical, sexual or verbal abuse, patient neglect or mistreatment." The policy stated employees of the facility were responsible for patient safety and must report any knowledge of patient abuse/neglect. According to the policy, "elder abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk	A 145	The facility had no effective process in place to keep the patient free from all forms of abuse and harrassment. Ten patient charts were reviewed and the facility failed to protect the rights of six of the patients. For patient #3 the facility failed to document the adminstration of medications. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 200.201 Patient Rights, policy 200.421 Continuum of Care, policy 600.034 Medication Administration (Pharmacy), and 700.707 Medication Administration (Nursing). Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO) The facility had no effective process in place to keep the patient free from all forms of abuse and harassment. Ten patient charts were reviewed, and the facility failed to protect the rights of six of the patients. For patient #4 the facility failed to provide and administer an ordered medication, failed to notify physician of medication omission and change in patient status. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on Policy 200.201 Patient Rights, policy 600.098 Drug Product Selection - Formulary. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO)	3/1/2019 3/1/2019

Signature: _____ Date: 3/1/19

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

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A 145	Continued From page 27 of harm to a vulnerable adult." Observation of the facility on 01/23/19 at 4:30 PM, 01/24/19 at 5:30 PM, and 01/29/19 at 9:00 AM, revealed the facility's inpatient census ranged from three (3) to six (6) on the medical-surgical unit and three (3) to eight (8) in the ED. Review of physician credentialing filesrevealed the facility had three Internal Medicine/General Practice physicians and one General Surgeon. Interview with the Chief Nursing Officer (CNO) on 01/30/18 at 6:20 PM and with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed the facility did not provide intensive/critical care services and had no policy/procedure in place regarding the scope of services that the medical surgical unit could provide. Further interview revealed the General Surgeon was not on call at the facility and only conducted scheduled outpatient surgeries one day per week. In addition, the facility did not have anesthesia services available on call and the Radiology Department was not in house from 12:00 AM to 7:00 AM, but was on call. 1. Review of the Emergency Department (ED) record for Patient #5 revealed the patient presented via Emergency Medical Services (EMS) on 11/26/18 and was triaged at 3:35 PM for left leg swelling, pain, and a wound to the left leg that had been present for one week. According to the ED physician's note, Patient #5 sustained a "direct blow" to the left leg "several days ago" and had increased, pain, redness, and swelling since that time.	A 145	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/19/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes. (CEO) The facility did not have an effective system for ensuring social services was consulted. An electronic reflex process was intitiated. A reflex was attached to questions in flowchart pertaining to social services. When nursing staff choose answers to questions, it sends an electronic trigger to social services department and staff. Licensed nursing staff will be in-serviced on policy 200.606, Nursing Discharge. This will be verified by way of an in-service attendance log. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. (ACNO) In-service education related to proper nursing documentation will be provided by Nurse Educator from Lincoln Memorial University. This will be verified by way of the in-service attendance log. (CNO) The reporting and follow up on medication errors was identified in the survey findings. The Medication Error Policy 600.085 has been in-serviced to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and MEC. This will be verified by the in-service attendance log. Licensed nursing staff will be in-serviced on policy 600.085, Medication Error. This will be verified by way of the in-service attendance log. Licensed nursing staff will be in-serviced on policy 600.085, Medication Error. This will be verified by way of the in-service attendance log. (ACNO)	3/1/2019 3/1/2019 3/1/2019 3/1/2019

Signature: _____ Date: 3/1/19

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A 145	Continued From page 28 Review of a Venous Doppler Study of the left leg completed on 11/26/18 at 4:13 PM revealed that Patient #5 was "Positive for DVT" with no compressibility of superficial femoral vein of the left thigh" (Deep Vein Thrombosis or blood clot). Review of the medical record for Patient #5 revealed the facility admitted the patient on 11/26/18 with diagnoses of Cellulitis of Left Lower Leg (skin infection), Deep Vein Thrombus of Left Thigh (blood clot), and Left Hip Pain. 1.a. Review of Patient #5's History and Physical (H&P) dated 11/27/18 at 11:23 AM revealed Physician #5 documented that "[Patient #5] complains of significant pain in the left hip area." Continued review of the H&P revealed upon examination Patient #5 was "afebrile to touch and in distress due to pain in the left hip area." Review of a Physical Assessment dated 11/27/18 at 4:00 PM revealed Patient #5 continued to have pain. According to the assessment, the patient had moderate, generalized pain with signs of pain that included diaphoresis (sweating) and restlessness. The assessment revealed pain medication was administered and a follow-up assessment was documented at 5:30 PM; however, the assessment was not completed and the patient's pain level was not documented. There was no documented evidence that an x-ray of Patient #5's left hip was completed until the day after admission to the facility. Review of Patient #5's physician orders revealed Physician #5 ordered a left hip x-ray on 11/27/18 at 11:00 AM. Review of the left hip x-ray report completed on 11/27/18 at 11:38 AM revealed the clinical indication for the x-ray was "Left Hip Pain; Patient	A 145	Licensed nursing staff will be in-serviced on policy, policy 200.201 Patient Rights 200.407 Identifying and Reporting Victims of Abuse and Neglect. This will be verified by way of the in-service attendance log. (ACNO)	3/1/2019
			All Medical and Nursing staff will be in-service on Policy 200.201 Patient Rights, Policy 200.401, Scope of Care (Facility). This will be verified by the in-service attendance log. (ACNO)	3/1/2019
			Due to not adhering to the AHA Standards and NIH Stoke Protocol the facility requested that the ED contract company in-service their own physicians on the stroke protocol. Inservice logs and verification from in-service will be sent and placed in the employee files by 3/7/19. (CNO)	3/1/2019
			Re-inservice the Emergency Department regarding the stroke policy 700.321 and the requirement to provide the standard of care. The Emergency Department Manager will collect data on " Door to MD" and "Door to Thrombolytics" as part of the QAPI process through chart audits, logs from specific departments, and running reports from within the EMR. All QAPI activities will be reported by managers through a weekly QAPI committee meeting so immediate action can be taken. (ACNO)	3/1/2019
			Re-inservice the Radiology Department regarding the stroke policy 700.321 Stroke Protocol. The Radiology Department Manager keeps a daily log to monitor stroke protocols "Door to CT completed" and "Door to CT report" as part of the QAPI process that meets weekly. This will be verified by the QAPI meeting minutes. (Director of Radiology)	3/1/2019
			The Emergency Department staff will be re-educated by the ED Manager on the Mission Statement, the employee job descriptions and the Policies and Procedures for the Emergency Department. (ACNO/Human Resources Director)	3/1/2019
			The Radiological Policy 300.421 was edited to change on call technologist response time for a stroke protocol to be within 15 minutes. This policy will be taken to QAPI to MEC and to the Governing Board for approval. The Radiology staff will be in-service on this policy changes. (Director of Radiology)	3/1/2019
			The Radiological Policy 300.441 was edited to change on call technologist response time to be within 15 minutes. The policy will be taken to QAPI to MEC and to the Governing Board for approval. The Radiology staff will be in-serviced on this policy changes. (Director of Radiology)	

Signature: _____ Date: 3/4/19

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A 145	Continued From page 29 fell out of Bed." Continued review revealed the conclusion was, "Acute relatively undisplaced fracture proximal shaft of femur" (upper thigh bone). Review of Patient #5's progress note dated 11/28/18 at 9:30 AM and 2:00 PM revealed the patient continued to have moderate left hip pain and pain medication was administered. Review of physician credentialing files revealed no physician was credentialed to conduct surgical repair of a hip fracture. However, there was no documented evidence the facility attempted to transfer Patient #5 for treatment of the hip fracture until 11/28/18, the next day. According to the Nursing Progress Notes, another acute care hospital was not contacted for transfer until 11/28/18 at 11:30 AM. At 12:00 PM on 11/28/18, Registered Nurse (RN) #2 documented that the facility accepted the patient's transfer and the patient was transferred on 11/28/18 at 3:53 PM by Emergency Medical Services. Review of the Discharge Summary dated 11/28/18 at 11:32 AM revealed Patient #5 was "Positive for a DVT of left thigh" and had an "acute relatively undisplaced fracture proximal shaft of femur." Interview with Physician #5 on 01/29/19 at 4:35 PM revealed that he knew Patient #5 well and when he examined the patient the day after admission, he found the patient to be in pain. Physician #5 stated that because it was difficult to communicate with Patient #5, he often ordered radiological studies to rule out any broken bones. Physician #5 stated when Patient #5's x-ray was positive for a fracture of the femur, he contacted	A 145	The CEO was found to not be in compliance with overseeing the facility by ensuring that necessary equipment was in proper working order. The ED Central Cardiac Monitor has been repaired by DTG, initial payment submitted 2/11/2019 and final payment was submitted on 2/19/2019. Central monitor back in operation3/1/2019. (ACNO/CEO) The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached. (CEO)	3/1/2019 3/6/2019

Signature: _____ Date: 3/2/19

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A 145	Continued From page 30 a General Surgeon who used to work with him at the facility. Physician #5 stated that to his knowledge, surgeons conducted orthopedic repairs. Continued interview revealed that when he was notified the next day that the physician could not do the repair, he arranged for Patient #5 to be transferred to another acute care facility. Interview with the Discharge Planner on 01/24/19 at 4:24 PM revealed she was familiar with Patient #5 because the patient was discharged from the hospital. She stated she spoke with Physician #5 regarding the timeframe for transferring the patient. According to the Discharge Planner, Physician #5 attempted to transfer Patient #5 on 11/27/18 to a physician that he used to work with; however, the physician did not get back to him until 11/28/18 and told him he did not have the "right equipment at the facility he worked at now and he could not accept the patient." At that time, Physician #5 arranged to transfer the patient to another acute care facility that provided orthopedic surgery. The Discharge Planner stated she was surprised that Physician #5's first attempt to transfer was to a "Critical Access Hospital" and was to just a "General Surgeon," not an "Orthopedic Surgeon." 1.b. Review of the ED physician's note dated 11/26/18 at 5:23 PM for Patient #5 revealed the patient's abdomen was soft and non-tender. Further review of the ED record revealed Patient #5 was admitted for further evaluation due to DVT, abrasion, and cellulitis to the left lower leg and hypokalemia. According to the Patient Progress Notes dated 11/26/18 at 8:18 PM, Patient #5 weighted ninety-five (95) pounds on admission, and review of admission orders dated 11/26/18 revealed an order for a regular diet.	A 145		

Signature: _____ Date: 3/11/19

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A 145	Continued From page 31 However, a review of the Initial Physical Assessment dated 11/26/18 at 8:29 PM revealed Patient #5 was at risk for aspiration due to difficulty swallowing and chewing and was fed by a feeding tube. Further review revealed the patient had facial weakness and received enteral nutrition (feeding tube). The assessment then referred to a "nutrition E-Form" for nutrition information. However, there was no documented nutritional information. Further, there was no evidence that staff notified the physician that the patient could not consume an oral diet and obtained orders to feed the patient via the patient's feeding tube. Review of Patient #5's Progress Notes revealed staff documented the patient had no intake (food or tube feeding) on 11/27/18 at 8:07 AM, 12:31 PM, 5:49 PM, 10:19 PM, and 11/28/18 at 6:32 AM. On 11/28/18 at 8:00 AM, an RN documented that good nutrition and adequate fluid intake was encouraged, even though staff documented on admission that the patient had a feeding tube with trouble swallowing. Interview with the Registered Dietitian (RD) on 01/29/19 at 1:30 PM revealed he should assess all patients who had a feeding tube or wounds to ensure they were receiving adequate nutrition to meet the patient's needs. However, the RD stated staff did not notify him that Patient #5 had a feeding tube and he had not assessed the patient. According to the RD, the facility had only requested a consultation for one patient during the approximately eight months that he had been contracted with the facility. The RD stated he was unsure why the facility did not consult him for clinical consultation.	A 145		

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A 145	Continued From page 32 Interview with the Dietary Manager on 01/24/19 at 11:10 AM revealed she did not consult the RD related to inpatients' needs due to facility budget contraints. Interview with Registered Nurse (RN) #2 on 01/24/19 at 2:30 PM revealed he was not sure why Patient #5's physician was not contacted for tube feeding orders. Interview with the Assistant Chief Nursing Officer (ACNO) and the CNO on 01/30/19 at 6:00 PM revealed all patients with a feeding tube should have a physician's order to address the patient's nutritional needs. They stated it was the expectation of the facility that each patient would be fed, unless there was an order to be NPO (nothing by mouth). 1.c. Review of the facility policy titled "Medication Administration," dated August 2017, revealed staff should provide care, treatment, and services using the most current physician orders. The policy stated the definition of "STAT" when used with medication orders meant the medication should be administered within fifteen (15) minutes of the order. Review of Patient #5's potassium level dated 11/26/18 at 4:20 PM revealed the patient's level was low at 2.7 (normal is 3.5 to 5.3). Review of physician orders dated 11/26/18 at 5:09 PM, revealed potassium was ordered "STAT." According to Patient #5's History and Physical (H&P) the patient had "life threatening hypokalemia [low potassium] which will be supplemented." However, review of Patient #5's Medication Administration Record (MAR)	A 145		

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A 145	Continued From page 33 revealed Potassium was not administered until 11/26/18 at 6:56 PM (one hour and forty-seven minutes after it was ordered to be administered STAT). Further review of Patient #5's physician orders revealed the following medications were ordered to be given "STAT" (immediately): Lovenox 90 mg injection (treats and prevents blood clots) was ordered at 11/26/18 at 4:44 PM; Zofran 4 mg (used to treat nausea and vomiting) intravenously (IV); and Morphine 4 mg IV was ordered on 11/26/18 at 5:02 PM. However, review of Patient #5's Medication Administration Record (MAR) dated 11/26/18 revealed the facility did not administer the patient's medications STAT as required by the facility's protocol. Lovenox was not administered until 11/26/18 at 5:30 PM (45 minutes after the medication was ordered); and Zofran and Morphine were not administered until 11/26/18 at 6:56 PM (one hour and fifty-four minutes after it was ordered). Interview with Registered Nurse (RN) #8 on 01/28/19 at 10:30 AM revealed that she recalled Patient #5 presenting to the ED with a swollen leg and was diagnosed with a DVT. RN #8 stated the patient's medications were administered late because she did not have a needle that was needed to access the patient's port-a-cath (a catheter that is inserted in a large vein above the heart). RN #8 stated the ED had been out of the needles for "some time." RN #8 stated she attempted to start an IV on the patient two (2) times, but was unsuccessful and waited for another nurse to start an IV for the patient. RN #8 stated that she could not recall whether she	A 145		

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A 145	Continued From page 34 notified the physician that Patient #8 had not received the medications STAT (within 15 minutes). 1.d. Review of the facility's Skin Integrity/Pressure Ulcer policy, approved August 2018, revealed the purpose of the policy was to ensure all patients admitted to the facility were assessed for skin integrity. Review of the Plan for Assessment and Reassessment of Patients policy, approved February 2017, revealed patient assessments were initiated upon admission and continued throughout the patient's stay. The goal of patient assessment and reassessment was to determine the type and kind of care the patient required initially, the follow-up and response to that care, and frequent evaluations for changes in patient status and needs in order to change the plan of care. Review of the Emergency Department (ED) Record for Patient #5 revealed he/she presented via Emergency Medical Services (EMS) on 11/26/18 and was triaged at 3:35 PM for left leg swelling, pain, and a wound to the left leg that had been present for one week. Review of the ED physician's note dated 11/26/18 at 3:48 PM revealed Patient #5 was paralyzed on the left side as a result of a prior stroke. The note also stated the patient had hit his/her leg against the wheelchair several days ago and had an abrasion on the left lower leg. Review of a skin assessment completed in the ED on 11/26/18 at 4:02 PM revealed Patient #5's left lower extremity was red and swollen with a	A 145		

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A 145	Continued From page 35 5.5 by 1 centimeter open wound to the left lower extremity. The nursing note stated the wound bed was red with areas of yellow granulation and the wound edges were black. The note stated no drainage or odor was noted. Further review of the ED record revealed Patient #5 was admitted for further evaluation due to DVT, abrasion, cellulitis to the left lower leg, and hypokalemia. Review of Patient #5's initial nursing assessment dated 11/26/18 at 8:29 PM revealed staff documented that the patient had a skin tear with yellow granulation to the left lower leg with redness and edema around the area. According to the patient progress note dated 11/26/18 at 10:37 PM, a dressing to the left lower leg completed in the ED at 4:00 PM was intact. Review of Patient #5's History and Physical (H&P) dated 11/27/18 at 11:23 AM revealed the patient had cigarette burn marks on the right middle finger and the right ring finger and an abrasion and cellulitis of the left lower leg. There was no documented evidence that the burns had been identified during the admission nursing assessment. In addition, the H&P stated the plan was to do wet to dry dressings and apply Silvadene cream to the right hand; however, the treatment was never completed while Patient #5 was at the facility. Further review of Patient #5's medical record revealed no documented evidence the facility reassessed the wound to the patient's left lower leg or the patient's fingers and no evidence treatment was provided to the areas. Review of patient progress notes dated 11/28/18 at 8:10 AM	A 145		

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A 145	Continued From page 36	A 145		

and 8:00 PM, revealed Patient #5 had no dressings to the skin, had no edema, and the patient's skin was within normal limits.

Interview with Registered Nurse (RN) #8 on 01/28/19 at 10:30 AM revealed she could not recall if Patient #5 had an open wound or not; however, she stated that she had never taken pictures of wounds or pressure sores; or documented a detailed description of the pressure ulcer as an RN in the ED.

Interview with the Assistant Chief Nursing Officer on 01/30/19 at 6:00 PM revealed that it was the expectation of the facility for all nursing staff to follow facility policies. The Assistant CNO stated it was the policy of the facility for all wounds to be pictured, documented on a wound care sheet, and to have a treatment ordered.

Interview with RN #2 on 01/24/19 at 2:30 PM revealed that he could "kind of" recall Patient #5. RN #2 stated that he did not know what happened with Patient #5 or why he/she remained in the facility after they were aware the patient's hip was broken. Further, RN #2 did not know why there was no assessment of Patient #5's leg or finger wounds and did not recall Physician #5 ordering any type of treatments to be provided to the wounds.

Interview with the Assistant CNO on 01/28/19 at 4:00 PM revealed that she was unware of the facility failures regarding Patient #5 not receiving medications in a timely manner; not receiving wound care; not receiving g-tube feeding; and no order regarding feeding until they were brought to her attention at the time of this survey. Continued interview with the Assistant CNO revealed that

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A 145	Continued From page 37 currently Quality Review of Nursing Documentation and ensuring Physician orders were being completed was not being conducted. Review of the medical record for Patient #5 from Facility #2 revealed Facility #2 admitted Patient #5 on 11/28/18 with a "left femur fracture following a fall." Review of the History & Physical for Patient #5 revealed the patient had the following: Acute Undisplaced Fracture Proximal Left Shaft of Femur, Left Superficial Femoral Vein DVT, Cellulitis, and Ulcer of the Left Lower Extremity, CVA with Left Hemiparesis, Dysphagia Status Post PEG Tube Placement, Bedbound, and Probable Physical Abuse by family. The hospital plan was to admit the patient, tube feeding, orthopedic consult, IV antibiotic, wound care consult, and case manager consult for possible Adult Protective Services consultation. Further review of the Discharge Summary revealed the facility discharged Patient #5 on 12/03/18 to a long-term care facility with discharge diagnoses "Underweight plus mild malnutrition." According to the record, the patient's weight was 99 pounds on discharge. 2. Review of Patient #2's medical record revealed the patient presented to the facility Emergency Department (ED) via ambulance on 10/10/18 at 7:58 AM with Syncope (temporary loss of consciousness usually related to insufficient blood flow to the brain) and a left arm injury. A review of the ED physician's note dated 10/10/18 revealed the physician examined Patient #2 at 8:11 AM and documented the patient had two syncopal episodes that morning after standing. The note stated the patient lost consciousness and collapsed. The note further	A 145		

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A 145	Continued From page 38 stated the patient had sustained a wrist fracture the night before after sustaining a fall. A review of the ED physician's note dated 10/10/18 at 8:28 AM, revealed Patient #2 developed chest discomfort and an EKG (a test of the heart's electrical activity used to detect heart conditions) was obtained. According to the note, the patient's EKG was unchanged when compared to a previous EKG completed in July 2018. In addition, the patient's Troponin (an elevated troponin level may indicate some degree of damage to the heart) was within normal limits. Further review of the physician's notes for 10/10/18 at 9:36 AM revealed Patient #2 was stable and the chest discomfort was relieved by nitroglycerin. Review of physician orders dated 10/10/18 at 11:34 AM revealed Patient #2 was being admitted to Physician #7's care for observation due to chest pain with syncope and to rule out a myocardial infarction (MI or heart attack). Review of Physician Orders for Patient #2 dated 10/10/18 at 11:35 AM revealed an order to repeat a test of the patient's Troponin level and conduct another EKG at 1:00 PM and 5:00 PM on 10/10/18 due to chest pain. However, there was no documented evidence the facility obtained an EKG or Troponin level at 1:00 PM on 10/10/18. The facility completed the tests at 5:00 PM and the patient's Troponin level was within normal limits and the EKG showed a normal rhythm with an "abnormal" EKG. Further review of physician orders dated 10/10/18 at 5:50 PM revealed an order to conduct	A 145		

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A 145	Continued From page 39 orthostatic blood pressures the next morning (10/11/18) (process of taking a patient's blood pressure while lying, sitting, and standing. An abnormal decrease in blood pressure when a person stands up can cause syncope). However, there was no documented evidence the facility conducted orthostatic blood pressures. Further review of physician orders dated 10/11/18 at 9:55 AM, revealed an order to obtain an EKG "STAT" for Patient #2. A review of the EKG report dated 10/11/18 at 10:14 AM revealed Patient #2's heart rate was 80, and the patient had developed atrial fibrillation (an irregular and often rapid heart rate that can increase your risk of stroke, heart failure, and other heart-related complications) and continued to show acute ischemia. Further, a repeat EKG dated 10/11/18 at 10:19 AM, four minutes later, revealed the patient's heart rate was 92, and the patient continued to have atrial fibrillation and acute ischemia. However, there was no documentation that Patient #2's physician was notified that the patient had developed atrial fibrillation. Review of a nursing note dated 10/11/18 at 10:45 AM revealed Registered Nurse (RN) #2 documented that when transferring Patient #2 to bed after having an x-ray, the patient had a syncopal episode and became diaphoretic (sweaty) and hypotensive (low blood pressure). The nursing note stated the patient's physician was notified and a new order was obtained. Review of a physician order dated 10/11/18 at 11:15 AM revealed an order to conduct another EKG. According to the nursing notes dated 10/11/18 at 11:19 AM, an EKG was obtained, the patient was in atrial fibrillation, and the patient's physician was notified. However, there was no	A 145		

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A 145	Continued From page 40 documented evidence that another EKG was obtained. Further review of Patient #2's nursing notes revealed at 1:43 PM on 10/11/18, staff documented that the patient was having atrial fibrillation, "went into asystole (no heart beat), and converted to sinus rhythm." The nurse documented that the patient was sitting up in bed with no distress. According to the note, Patient #2's physician was notified and the physician requested the patient be transferred to another facility with cardiology. Further review of Patient #2's medical record revealed on 10/11/18 at 4:10 PM, staff documented that the patient heart rate was 69 and the patient was having Premature Ventricular Contractions (PVC) (irregular heartbeat); however, there was no further documentation of an assessment of the patient's condition. According to a nursing note dated 10/11/18 at 4:30 PM, Emergency Medical Services (EMS) was notified of the need to transport Patient #2 and the patient left the facility with EMS at 6:00 PM on 10/11/18 for transport to Facility #4. A review of Patient #2's Discharge Summary revealed Physician #7 documented that the patient "evolved" to atrial fibrillation with "pause" and was transferred "in case need pacer [pacemaker]". Interview with RN #7 on 01/28/19 at 2:35 PM revealed that she really could not recall specifics about Patient #2; however, she did state that she was the RN that took verbal orders for the patient from Physician #7. RN #7 stated that Physician #7 was bad to come back and "add" orders and	A 145		

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A 145	Continued From page 41 could see how some of those orders for Patient #2 were missed. RN #7 stated that evidently nursing staff had just missed the 1:00 PM orders for an EKG and troponin level. Interview with RN #2 on 01/29/19 at 5:20 PM revealed he did not recall taking care of Patient #2 on 10/11/18. RN #2 stated he did not know why the EKG or the Troponin level was not done at 1:00 PM or why orthostatic blood pressures had not been taken. Continued interview with RN #2 revealed that he felt certain that he had spoken with Physician #7; however, he could not recall what he was told nor was there any documented evidence that he had contacted the physician. Interview with the Assistant Chief Nursing Officer (CNO) on 01/28/19 at 4:00 PM revealed that she did not know why the EKG and troponin level were not completed. The Assistant CNO stated that RN #2 failed to document according to facility policy and failed to ensure physician orders were followed. Continued interview with the Assistant CNO revealed that currently Quality Review of Nursing Documentation and ensuring Physician orders were being completed was not being conducted. An interview was requested with Physician #7; however, he declined. Review of Patient #2's medical record from Facility #4 revealed Facility #4 admitted Patient #2 on 10/11/18 with diagnoses that included Syncope, Atrial Fibrillation, Coronary Artery Disease, Hyperlipidemia, Dementia, Essential Hypertension, and Closed Fracture of the Left Wrist. Patient #4 had a heart catheterization (a	A 145		

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A 145	Continued From page 42 procedure where a catheter is inserted to check the vessels of the heart) on 10/12/18 along with an Echocardiogram (a procedure that uses electrodes to check your heart rhythm and ultrasound technology to see how blood moves through your heart). Facility #4 made recommendations for medical management of Atrial Fibrillation for Patient #4 and started the patient on a low dose of Sotalol (a medication used to assist with rhythm disturbances of the heart). Facility #4 discharged Patient #2 home on 10/13/18 with Home Health and follow-up appointments. 3.a. Interview with the Assistant Chief Nursing officer (ACNO) on 01/28/19 at 4:00 PM revealed the facility did not have a policy/procedure/protocol regarding the scope of care the facility could provide for patients admitted to the medical surgical unit of the facility. However, the ACNO acknowledged the facility did not have the ability to care for patients with a diagnosis of Acute Cerebrovascular Accident (CVA/Stroke), or patients who were having difficulty swallowing or signs of Aspiration. The ACNO stated the facility did not have a neurologist, physical/occupational/speech therapy, etc. to care for a patient with a diagnosis of Cerebrovascular Accident (CVA/stroke) on an inpatient basis. Further, the ACNO stated the facility's Acute Stroke Practice Standard for the facility's Emergency Department should also be implemented when an inpatient had signs/symptoms of a stroke. Review of the facility's policy, Acute Stroke Practice Standard for the Emergency Department (ED), undated, revealed patients exhibiting signs and symptoms of a stroke should receive imaging	A 145		

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A 145	Continued From page 43 including a non-contrast head computed tomography (CT) scan within twenty (20) minutes of arrival. Review of Patient #8's medical record revealed Physician #7 evaluated the patient in his office on 01/21/19, and the patient was admitted directly to the medical surgical unit with diagnoses that included Acute CVA (cerebrovascular accident/stroke), Old CVA, and a recent fall with Concussion, even though the facility did not have the capability to treat a patient who was having a stroke. Further review of Patient #8's record revealed the patient was not oriented to person or place, and the patient was confined to bed. The patient also had diagnoses that included Phosphatemia (presence of phosphate in the blood), Chronic Kidney Disease Stage 4, and a surgical history of a left nephrectomy (removal of a kidney). The admission nursing assessment dated 01/21/19 revealed the patient arrived at the medical surgical unit at 5:25 PM. The patient was "disoriented x 3," attempting to eat, "but holding a Kleenex to [his/her] mouth and stated [he/she] was having trouble swallowing." The patient's spouse also informed staff the patient "has been unable to walk or communicate with him today." The patient was unable to do "pushes or grips" during neurological assessments, and was "very weak on the right side, mouth drooping noticed on [his/her] right side." Interview with Registered Nurse (RN) #7 on 01/24/19 at 3:10 PM revealed she admitted Patient #8 to the facility on 01/21/19 and stated, "I was worried about what I was dealing with." She	A 145		

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A 145	Continued From page 44	A 145		

stated the patient was drooling, hand grips were not equal, and the patient had visible deficits that were signs of a stroke. She also stated she did not feel like the patient's needs could be met at the facility. RN #7 stated at times she felt physicians admitted patients that did not receive the level of care they required.

Review of Patient #8's physician orders dated 01/21/19 revealed a computerized tomography (CT) scan was ordered; however, the scan was not completed until 6:36 PM, approximately one hour after the patient arrived at the hospital. Review of the CT scan results revealed the scan was a "suboptimal study due to movement artifacts, no obvious bleeding or midline shift is noted and if the patient has persistent symptoms, a repeat study without movement artifacts would be useful."

Interview with Registered Nurse (RN) #3 on 01/22/19 at 8:20 PM revealed she cared for Patient #8 during the night shift (6 PM-6 AM) on 01/21/19, the night the patient was admitted. She stated the patient "should never have been admitted here and the doctor put [his/her] life in jeopardy." She stated the patient had visual neurological deficits on assessment, and signs of a "stroke" which included facial drooping and drooling. The RN stated the patient also had difficulty swallowing, and was placed on aspiration precautions. The RN stated however, that the facility no longer employed speech therapists for consultation, so "we [nursing] just do the best with what we have left here." RN #3 stated the patient required one on one care throughout the shift, related to confusion, attempts to ambulate without assistance, and attempts to dislodge his/her IV access. The RN

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A 145	Continued From page 45 stated she contacted Physician #7 "early in the shift" regarding the patient's neurological deficits, difficulty swallowing, and the need to transfer the patient to another facility with an intensive care unit. However, Physician #7 told the RN "Don't call me back anymore. We'll sit on it tonight and transfer [him/her] out tomorrow." The RN stated she also contacted the physician one other time during the shift regarding the patient's condition; however, the physician did not transfer Patient #8 to another facility until the next morning, 01/22/19. An interview with Physician #7 was requested on two (2) separate occasions during the investigation; however, no return call was received. 3.b. Review of Patient #8's medical record revealed the facility admitted the patient on 01/22/19 with diagnoses of Acute Cerebrovascular Accident (CVA/stroke), Old CVA, a recent fall with Concussion, Phosphatemia (presence of phosphate in the blood), Chronic Kidney Disease Stage 4, and a surgical history of a left nephrectomy (removal of a kidney). Further review of Patient #8's record revealed the patient was not oriented to person or place and the patient was confined to bed. Review of Patient #8's physician orders dated 01/21/19 revealed orders to administer Cardizem ER (medication used to treat high blood pressure, abnormal heart rhythms, and chest pain) one hundred eighty (180) milligrams (mg) twice daily, Renvela (phosphate binding drug for patients with chronic kidney disease), and Biotin (water soluble B vitamin).	A 145		

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A 145	Continued From page 46 A review of Patient #8's Medication Administration Record (MAR) revealed Cardizem was not administered on 01/21/19 at 9:00 PM or on 01/22/19 at 9:00 AM as ordered. Further review revealed Renvela and Biotin were not administered on 01/22/19 at 9:00 AM as ordered. Staff documented that the medications were "omitted" because medication was "absent from the unit." The MAR also stated Biotin was "not on the formulary patient will need to bring own." There was no documented evidence that the facility notified the patient's physician that his/her medications were not available. Interview with Registered Nurse (RN) #3 on 01/22/19 at 8:20 PM revealed she cared for Patient #8 during the night shift (6 PM-6 AM) on 01/22/19, the night the patient was admitted. She stated Cardizem ER was not available and had not been available for at least one week because she recalled another patient had also needed the medication the week before. She stated she had not notified the patient's physician that the medications were not available to be administered as ordered. According to RN #3, "not having the medications we need here happens so often, it's just became a normal occurrence, and we aren't notifying the physicians like we should." 4. Review of Patient #11's medical record revealed the patient arrived at the facility Emergency Department (ED) on 09/20/18 at 9:40 PM and was evaluated by Physician #8. The patient had complaints of upper quadrant pain radiating to the chest area, abdominal pain with guarding present in the right upper quadrant region (pain was nine on a zero to ten scale), chills, diarrhea, nausea, and vomiting.	A 145		

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A 145	Continued From page 47 Further review of Patient #11's record revealed he/she previously had been evaluated by Physician #1 on 08/30/18 and was diagnosed with choledocholithiasis (stone in the common bile duct), with cholangitis (infection of the liver bile duct), gallstones, and pancreatitis (inflammation of the pancreas). Patient #11 had a scheduled appointment with Physician #1 on 10/05/18 for further evaluation and treatment. Further review of Patient #11's medical record revealed even though the facility was "uncertain if anesthesia was available," Patient #11 was admitted to the facility for surgical services on 09/21/18 under Physician #5's care and Physician #1 was consulted. Review of Physician #1's notes revealed he evaluated Patient #11 on 09/21/18, and his recommendations were, "I think the patient needs to transferred where they can do surgery." The physician also stated, "I do not have access to any instrument here, nor do I have access to anesthesia, this patient needs to have ERCP [endoscopic retrograde cholangiopancreatography], stone removed and needs to be transferred." However, there was no documented evidence that the facility arranged for transfer of Patient #11 to another facility for further care and treatment until 09/24/18 (3 days after Physician #1 documented the need for transfer). Further review of Patient #11's medical record revealed from 09/21/18 through 09/24/18, the facility treated the patient with intravenous (IV) antibiotics and fluids. Review of Patient #11's physician orders dated 09/21/18 revealed the	A 145		

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A 145	Continued From page 48 patient could also receive Dilaudid IV as needed for pain and Zofran IV as needed for nausea. Review of Patient #11's Medication Administration Record (MAR) revealed staff administered Dilaudid on 09/21/18 at 8:30 PM and on 09/22/18 at 11:44 AM for complaints of pain which the patient rated at an eight (8) on a scale of 0-10. Follow up documentation revealed the medication was effective. Review of Patient #11's discharge summary dated 09/24/18 revealed the patient was transferred to Facility #3 to the services of Physician #1 for "immediate ERCP." The summary stated the patient had not previously been transferred as recommended because there had been no beds available. Review of Physician #1's documentation revealed he evaluated Patient #11 when the patient arrived at Facility #3 on 09/24/18. The physician's evaluation revealed the patient had a history of elevated liver function tests and acute pancreatitis. Physician #1 stated Patient # 11 could not be transferred "over the weekend to [a university hospital] as the patient had requested, because there were no beds available, however the physician was not aware the patient had not been transferred." The physician stated the patient had some pain, as the patient was recovering from pancreatitis. An interview was attempted with Patient #11 on 02/03/19; however, the attempt was unsuccessful. Interview with Physician #5 on 01/29/19 at 4:30 PM revealed he was Patient #11's primary	A 145		

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A 145	Continued From page 49	A 145		

physician during the hospital stay from 09/21/18 until he transferred the patient on 09/24/18 to receive the needed surgical procedure. Physician #5 stated he had not attempted to obtain a bed at any other facility so Patient #11 could receive the needed surgical procedure. Physician #5 acknowledged the facility was unable to meet the needs of the patient. He also stated the patient should not have been admitted to the facility, because staff were unsure if surgical services were available when the patient was admitted to the facility.

5. Review of Patient #3's medical record revealed the patient presented to the Emergency Department (ED) on 12/30/18 at 2:35 PM with severe left foot pain. The patient reported that he/she believed his/her foot was broken. According to the ED record, the side of the patient's left foot and little toe were blue in color and cold.

Review of physician orders dated 12/30/18 at 3:30 PM, revealed the physician ordered for Patient #3 to receive Lovenox (used to prevent and treat blood clots), Zosyn (antibiotic) 3.375mg every eight (8) hours IV, and Demerol (medication to treat pain) 25 mg every four (4) hours as needed.

Further review of Patient #3's ED record revealed the facility admitted the patient to the facility on 12/30/18 at 4:40 PM due to cellulitis and swelling. There was no documented evidence the facility administered the patient's medications while in the ED.

Review of Patient #3's Medication Administration Record (MAR) revealed no documented evidence

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A 145	Continued From page 50 that the facility administered Vancomycin until 12/30/18 at 11:19 PM, approximately eight hours after the medication was initially ordered. Further, there was no documented evidence that the facility administered Lovenox on 12/30/18 when the medication was ordered. According to the MAR, Patient #3 did not get the first dose of Lovenox until 12/31/18 at 5:08 PM, more than twenty-four hours after the medication was initially ordered. Further review of Patient #3's MAR revealed the facility did not administer Zosyn until 12/31/18 at 1:55 PM, approximately twenty-three (23) hours and thirty (30) minutes after the medication was ordered. Further, even though Zosyn was only ordered to be administered every eight hours, staff documented that a second dose was administered at 2:21 PM, approximately 25 minutes after the first dose was administered. In addition, a review of the Emergency Department Documentation dated 12/30/18 at 3:45 PM revealed Patient #1's pain on a scale of zero to ten was a ten, the worst possible pain. Further review revealed that at 5:15 PM on 12/30/18, Patient #3's pain level was eight. There was no documented evidence that the facility administered medication to treat the patient's pain until 6:00 PM. Review of a CT Report dated 12/30/18 of the foot and ankle revealed Patient #3 had soft tissue swelling of the ankle and a 9.2 millimeter soft tissue ulceration of the fifth toe. Review of a Computed Tomography Angiography (CTA) report dated 12/30/18 at 4:13 PM revealed an approximately two-centimeter subtotal arterial occlusion (blockage) within the left femoral artery. However, there was no documented evidence	A 145		

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A 145	Continued From page 51 that the facility attempted to transfer the patient to another facility for care of the blockage until the next day, 01/01/19. Review of progress notes dated 01/01/19 at 12:00 PM revealed Patient #3 was transferred to Facility #4 by private vehicle. A review of Patient #3's medical record from Facility #4 revealed the patient was admitted on 01/01/19 with no pulses in the foot, swelling and redness to the left lower extremity, the fifth toe and surrounding area were purple and cool to touch, and there was an ulceration of the right side of the left foot. According to the Discharge Summary dated 01/10/19, and a Cardiac Catheterization note dated 01/08/19, the patient's femoral artery was patent; however, the popliteal artery had a six-centimeter occlusion that was treated. The patient was discharged on 01/10/19, under the care of home health for wound care to treat cellulitis and gangrene of the fifth toe. Interview with Registered Nurse (RN) #2 on 01/24/19 at 2:30 PM and RN #4 on 01/24/19 at 12:40 PM revealed they remembered providing care for Patient #3. RN #2 stated after reviewing the patient's medical record, that he could not recall why Patient #3 did not receive his/her medication in a timely manner. RN #4 stated the best that she could recall was that it was "pretty busy" the day Patient #3 was admitted. RN #4 stated that they did not have Zosyn on the floor, and someone had to go looking for the medication. Continued interviews revealed the RNs could not recall for certain why the Lovenox was not administered timely. The RNs stated that at one time the facility was out of Lovenox, and that was probably why Patient #3 missed the first dose of Lovenox.	A 145		

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A 145	Continued From page 52 Interview with the Assistant Chief Nursing Officer (CNO) on 01/28/19 at 4:00 PM revealed that she was unaware that Patient #3 had not received his/her medications timely. Continued interview with the Assistant CNO revealed that Quality Review of Nursing Documentation was not being conducted. 6. Review of Patient #4's record revealed the patient was admitted to the facility on 01/22/19 with diagnoses of Acute Congestive Heart Failure (CHF), Generalized Weakness, and Diabetes. Further review of Patient #4's medical record revealed the patient's physician had ordered Victoza 1.2 mg, to be administered daily at 9:00 AM. Further review revealed Patient #4 had physician orders dated 01/23/19 at 8:15 AM to notify the physician if the patient's blood sugar readings were below one hundred thirty (130) or above two hundred (200). The physician also ordered that staff notify him of Patient #4's urine output over the next two (2) hours. Review of Patient #4's medication administration record revealed the patient's 9 AM dose of Victoza for 01/23/19 was "omitted" and had not been administered. Review of Patient #4's blood glucose readings revealed at 10:57 AM on 01/23/19 the patient's blood sugar was 344; at 2:05 PM on 01/24/19 the patient's blood sugar was 219; and at 3:30 PM on 01/24/19, Patient #4's blood sugar was 237. However, there was no documented evidence that the facility notified the patient's physician that the patient's Victoza insulin was not available or that the physician was notified of the patient's elevated blood sugar levels.	A 145		

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A 145	Continued From page 53 Interview with Registered Nurse (RN) #2 on 01/29/19 at 5:00 PM revealed he had not administered Patient #4's Victoza insulin on 01/23/19 because it was not available at the facility. However, RN #2 stated he had not notified the patient's physician that the medication was not available and had not notified the physician of the patient's elevated blood sugar level. Interview with Patient #4's spouse on 01/23/19 at 5:00 PM revealed the patient was frequently admitted to the facility, including two (2) admissions "last month" (December 2018). The spouse stated, "They don't have a lot of medications here that [the patients] are ordered to receive. I try to remember to bring the needed medications, but sometimes I forget," and Patient #4 "just has to go without them while we're here."	A 145		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 263	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes. (Controller) The Governing Board is ultimately responsible for QAPI and implementation of the QAPI plan/process. The Governing Board did not take responsibility for appointing a CEO or overseeing the QAPI process. The Governing Board has now appointed a new CEO who will have the responsibility of overseeing the implementation of the QAPI process. The CEO is delegated responsibility by the Board to allocate adequate resources for quality improvement activities. (Newly appointed CEO)	2/22/2019 3/1/2019

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A 263	Continued From page 54 This CONDITION is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Quality Management Manual and Performance Indicators, it was determined the facility failed to implement and maintain an effective ongoing, hospital-wide, data-driven Quality Assurance and Performance Improvement (QAPI) Program. Interviews with the Chief Nursing Officer and Assistant Chief Nursing Officer revealed the facility had not conducted QAPI activity since the Director of QAPI resigned in July 2018. Review of QAPI Minutes revealed the last meeting was in October 2018 and review of Performance Indicators revealed the facility failed to conduct QAPI activities during the last quarter of 2018. Subsequently, review of patient records and interviews with staff revealed the facility failed to identify patient care and patient safety concerns and failed to develop action plans to address the concerns. (Refer to A0043, A0057, A0073, A0115, A0145, A0273, A0385, A0395, A0489, A0490, A0799, A0837, A0940, A0951, A0955, A1100, A1103, and A1104.)	A 263	The facility failed to have a functioning governing board and did not convene per policy. The CEO did not provide oversight of the QAPI plan and its implementation. A new governing board was established and met on 2/22/19. A MEC meeting was held on 2/20/19 at which time the following physician committee chairpersons were appointed: QAPI committee, Utilization review/ Risk Management; Blood Utilization / Infection Control / Surgery; and, P & T / Dietary. Also appointed were Medical Directors of Surgery and Home Health. A QAPI plan is in place with new performance indicators to reflect the monitoring related to the JTags. The data is being collected through chart audits, logs from specific departments, and running reports from within the EMR. All QAPI activities will be reported by managers through a weekly QAPI committee meeting so immediate action can be taken, then to the MEC monthly and to the Governing Board monthly. See attached QAPI plan. The QAPI plan was reviewed and approved by MEC on 2/20/19 and the new governing board as reflected in attached minutes. The new Governing Board appointed a new CEO on 2/22/19 who will provide oversight to ensure quality care is being provided. This may be verified by board minutes. (CEO/CNO) The facility failed to implement and maintain an effective, ongoing hospital-wide, data-driven QAPI program which failed to meet on a regular set schedule. The annual meeting calendar will be developed to ensure timely meetings by the necessary committees. The QAPI committee will meet weekly, this will be verified by committee attendance logs and minutes. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (Administrative Assistant)	3/1/2019 2/22/2019
A 273	DATA COLLECTION & ANALYSIS CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3) (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of	A 273	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes (Controller)	2/22/2019

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN KY MEDICAL CENTER	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

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A 273	Continued From page 55 performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Quality Management Manual and Performance Indicators it was determined the facility failed to have a Quality Assurance/Performance Improvement (QAPI) Program to measure, analyze, and track quality indicators and other aspects of performance to assess processes of care, hospital services, and hospital operations. Review of Performance Indicators revealed the facility failed to conduct QAPI activities during the last quarter of 2018 and interviews revealed no QAPI activity had occurred since the Director of QAPI resigned in July 2018. Subsequently, review of patient records and interviews with staff revealed the facility failed to identify patient safety concerns and failed to develop action plans to address the concerns to prevent reoccurrence.	A 273	The Governing Board is ultimately responsible for QAPI and implementation of the QAPI plan/process. The Governing Board did not take responsibility for appointing a CEO or overseeing the QAPI process. The newly appointed CEO will bear the administrative responsibility regarding the QAPI plan. The CEO will report any and all findings to the governing board and this will be verified by the minutes. (Newly appointed CEO) The facility failed to implement and maintain an effective, ongoing hospital-wide, data-driven QAPI program. The QAPI director resigned 7/2018, a physician sat on QAPI committee, attended meetings but had not been appointed. A QAPI physician committee chairman was appointed on 2/14/19. A permanent QAPI physician director, and Medical Director of Surgery, and a P&T physician appointed by MEC and approved by the new board. A QAPI plan was developed with new performance indicator for 2019. The plan was sent to and approved by MEC and the Governing Board. See attached minutes, and attendance log. The QAPI committee will now meet weekly, to ensure reporting of data collected related to all performance indicators, including new indicators related to the JTags, so that immediate action can be taken. (CEO) The facility failed to implement and maintain an effective, ongoing hospital-wide, data-driven QAPI program which failed to meet on a regular set schedule. The annual meeting calendar will be developed to ensure timely meetings by the necessary committees. This will be verified by committee attendance logs and minutes. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (Administrative Assistant)	3/1/2019 2/22/2019 2/22/2019

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A 273	Continued From page 56 The findings include: Review of the facility's Quality Management Manual dated June 2015 revealed the facility implemented a Quality Management System that documents the facility's basic policies and processes to achieve customer satisfaction while continually improving quality. The manual stated the facility's quality policy was dedicated to providing world class, comprehensive healthcare in the most compassionate and cost effective manner. According to the manual, the Chief Quality Offer was the Management Representative and had responsibilities that included ensuring that the processes for quality management were established and implemented, and reporting the facility's performance. The manual further stated the facility's Quality Management plan addressed key performance improvement focus areas. The facility provided the Key Performance Indicators for 2018; however, interview with the Chief Nursing Officer on 01/30/19 at 6:20 PM and with the Assistant Chief Nursing Officer on 01/30/19 at 6:20 PM revealed the facility had not been conducting quality reviews nor had a Quality Meeting (Performance Improvement) since October 2018. 1. Review of Patient #3's medical record revealed the patient presented to the facility Emergency Department (ED) on 12/30/18 at 2:35 PM with severe left foot pain and the patient's left foot and little toe were blue in color and cold. At 3:30 PM, the ED physician ordered Lovenox (anticoagulant-used to prevent and treat blood clots), Zosyn (antibiotic), and Demerol (narcotic medication to treat pain); however, staff failed to administer Lovenox and Zosyn until 12/31/18,	A 273		

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A 273	Continued From page 57 approximately twenty-four hours after the medication was ordered. In addition, Demerol was not administered until 6:00 PM, on 12/30/18, approximately three hours after it was ordered. In addition, review of Patient #7's medical record revealed the patient was admitted on 01/06/19 with Cellulitis to the right lower extremity (skin infection), early sepsis (a potentially life-threatening condition caused by the body's response to an infection), and a Stage 2 pressure sore. Patient #1's physician ordered Lovenox (anticoagulant) medication on 01/06/19 for the patient to prevent blood clots; however, there was no documented evidence the facility administered Lovenox until 01/07/19, approximately twenty-two (22) hours later. Patient #8 was directly admitted to the medical surgical unit on 01/21/19, with signs and symptoms of stroke. The facility failed to administer physician ordered medications that included Cardizem (treats high blood pressure/chest pain), Renvela (phosphate binding drug for patients with chronic kidney disease), or Biotin (water-soluble B vitamin) on 01/21/19 and/or 01/22/19 as ordered by the patient's physician. Review of the facility's formulary revealed Cardizem was listed; however, Interview with Registered Nurse (RN) #3 on 01/22/19 at 8:20 PM revealed the medication was not available. Further review of the formulary revealed Renvela and Biotin were not on the formulary; however, there was no documented evidence that the patient's physician was contacted regarding obtaining the medication or ordering a substitute.	A 273		

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A 273	Continued From page 58 Review of Patient #4's medical record revealed the facility admitted the patient on 01/22/19 for treatment of Congestive Heart Failure and Diabetes with physician orders to administer insulin. However, the facility failed to administer the patient's Insulin on 01/22/19 because it was not available at the facility. There was no documented evidence that the facility notified the patient's physician that the medication was not available and insulin was not administered. Subsequently, further review of Patient #4's medical record revealed Patient #4's blood sugar was elevated on 01/22/19 and 01/23/19; however, there was no documented evidence the facility notified the patient's physician as ordered when the patient's blood sugar was above two-hundred. Further review of the patient's medical record revealed on 01/23/19 at 8:15 AM, Patient #4's physician ordered a potassium supplement "now", discontinued the patient's Lasix medication. However, review of the patient's medication administration record dated 01/23/19 revealed the facility failed to administer the potassium supplement until 5:17 PM, nine hours after the "now" order. In addition, the facility administered Lasix on 01/23/19 at 5:12 PM, even though the medication was discontinued. In addition, there was no documented evidence the facility contacted the patient's physician with the patient's urinary output on 01/22/19, as ordered by the patient's physician. Review of the facility's Performance Indicators for 2018 revealed the facility was required to monitor medication variances that included medications that did not reach the patient (eight in the fourth quarter 2018), and patients responsible for their own medication (none for the fourth quarter 2018). In addition, the facility was required to	A 273		

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A 273	Continued From page 59 monitor the following situations for Pharmacy services: percentage of times antibiotics were administered within the one-hour window (85% in the fourth quarter); percentage of time diabetic medications were administered within the one-hour window (65.1% in the fourth quarter); and percentage of times anticoagulants were administered within the one-hour window (81.2% in the fourth quarter). The facility's threshold was 100%. There was no documented evidence the facility had implemented an action plan to ensure medications were available for patients and were administered per physician orders. Interviews with RN #7 on 01/24/19 at 3:10 PM, RN #4 on 01/24/19 at 5:20 PM, RN #3 on 01/22/19 at 8:20 PM, RN #2 on 01/24/19 at 1:50 PM, and with RN #11 on 01/29/19 at 6:45 PM revealed they never knew if the facility had physician ordered medications available. The RNs stated when a medication was ordered, they had to "hunt" in the facility to locate the medication, if they could find the medication at all. The RNs stated "hunting" for medications often caused a delay in treatment. RN #3 stated, "not having the medications we need here happens so often, it's just became a normal occurrence..." Interview with Pharmacist #1 on 01/23/19 at 2:45 PM revealed she continued to review Medication Administration Records and track medication errors as part of the facility's Performance Improvement program. She stated she also tracked whether antibiotics, diabetic medications, and anticoagulants (blood thinners) were administered in a timely manner. The pharmacist stated however, that if nursing staff did not circle a medication when it was not administered or notify pharmacy that a medication was not given	A 273		

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A 273	Continued From page 60 for any reason (unavailable), then she did not track those medications and they were not currently counted as medication errors. The pharmacist stated she had not identified that patients were not receiving medications as ordered or that medications were being administered late due to the unavailability of medications. Further interview revealed the facility had trouble obtaining medications because of a past due debt with the Pharmacy Distributor. The pharmacist stated she monitored medication stock, but could only order medications as the budget allowed; however, there was no documented evidence that staff had been educated about medication shortages/unavailability or that the facility was monitoring to ensure patients received ordered medications, or at least equivalent substitutes. In addition, the Director of Pharmacy stated pharmacy services were routinely discussed during Pharmacy and Therapeutics (P&T) Committee quarterly; however, there had not been a P&T Committee meeting since July 2018, when the physician that led the Quality Committee resigned. Review of the facility's Pharmacy and Therapeutics Committee Meeting Minutes revealed the committee had not met since 07/18/18. Review of the 04/10/18 minutes revealed twenty-eight medications/Intravenous (IV) Solutions were listed as "drug shortages." There was no documentation regarding why there were drug shortages or what actions the facility took to obtain the medications/substitutes. Review of the 07/18/18 minutes revealed drug shortages were "unable to determine due to lack of drug orders being placed."	A 273		

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A 273	Continued From page 61 Review of emails revealed effective 01/24/19, the facility did not have a Retail Pharmacy Vendor to supply medications to the facility. According to the email, the retail pharmacy was "turning over the handling of outstanding amounts to our legal team and will no longer be able to service the account." Observation, interview, and record review revealed the facility failed to have medications that were required by the facility's formulary, including antibiotics, intravenous fluids, and medications required for emergencies. In addition, observation and interview revealed the facility's Verapamil and Epinephrine (drugs used in emergencies) expired on 01/31/18, and the facility only had one vial of Activase (used to treat blood clots in patients having heart attacks and strokes). Interviews revealed the facility was unsure how they were going to obtain medications for use at the facility. 2. Review of the facility's Performance Indicators for 2018 revealed the facility monitored Surgical Services quarterly. The monitoring included ensuring procedures matched patient consent forms. According to the 2018 data, one hundred percent of the procedures matched the patient's consent form. However, review of a "Variance Report Investigation" dated 08/16/18 revealed the facility was aware that Patient #1 received a colonoscopy (a procedure to examine the colon from the rectum) "in error." Patient #1 had consented for an EGD (esophagogastroduodenoscopy is a procedure to examine the stomach and upper portion of the small intestine). Review of the patient's medical record revealed staff documented that a "time out" occurred and the patient's procedure was confirmed. According to the investigation, the RN "believes" he initiated the time out procedure for	A 273		

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A 273	Continued From page 62 an EGD; however, the room had been set up with equipment for a colonoscopy and "with no objections from any team members, an attempted colonoscopy was performed." The investigation revealed the Operating Room technician stated that the time out was conducted; however, staff stated the patient was supposed to have a colonoscopy. The CRNA initially stated the time out was conducted and the RN stated the procedure was supposed to be a colonoscopy, and then changed her mind and said it was supposed to be an EGD. 3. Further review of the facility's Performance Indicators for 2018 revealed the facility monitored the following inpatient care on the medical surgical unit: nutritional assessments, pain management assessment, and pain intervention. However, there was no data documented for the fourth quarter and no evidence the facility was monitoring the quality of care provided to patients in 2019. Record review revealed Patient #5 presented to the facility's Emergency Department (ED) on 11/26/18 with hip pain and was admitted with a physician order for a regular diet. However, review of the Initial Physical Assessment dated 11/26/18 at 8:29 PM revealed Patient #5 was at risk for aspiration due to difficulty swallowing and chewing and was fed by a feeding tube. Further review revealed the patient had facial weakness and received enteral nutrition (tube feeding). The assessment then referred to a "nutrition E-Form" for nutrition information. However, there was no documented nutritional assessment information. Further, there was no evidence that staff notified the physician that the patient could not consume an oral diet and obtained orders to feed the	A 273		

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A 273	Continued From page 63 patient via the patient's feeding tube. Review of Patient #3's medical record revealed the patient presented to the Emergency Department (ED) on 12/30/18 at 2:35 PM with severe left foot pain. The patient reported that he/she believed his/her foot was broken and the side of the patient's left foot and little toe were blue in color and cold. The patient's physician ordered Demerol (medication to treat pain) 25 mg every four hours as needed on 12/30/18 at 3:30 PM. Review of the Emergency Department Documentation dated 12/30/18 at 3:45 PM revealed Patient #1's pain on a scale of zero to ten was a ten, the worst possible pain. Further review revealed that at 5:15 PM on 12/30/18, Patient #3's pain level was eight. There was no documented evidence that the facility administered medication to treat the patient's pain until 6:00 PM. Further review of the Performance Indicators for 2018 for the Medical Surgical unit revealed no evidence the facility was required to monitor to ensure care was provided in accordance with physician orders or that physicians were notified of changes in patients' condition. Subsequently, there was no documented evidence that the facility identified that a social services consultation was recommended for Patient #9 on 01/16/19. Review of the patient's record revealed the patient had no running water at home or access to care and medications. However, the facility discharged Patient #9 home with no resources. In addition, review of Patient #2's medical record revealed the patient was admitted with chest pain and to rule out a heart attack on 10/10/18;	A 273		

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A 273	Continued From page 64 however, the facility failed to conduct heart testing, blood pressure monitoring, and laboratory testing to monitor the patient's cardiac status as ordered by the patient's physician on 10/10/18 and/or 10/11/18. When the patient developed a heart arrhythmia on 10/11/18, the facility failed to notify the patient's physician timely and Patient #2 was not transferred to an acute care facility for cardiac assessment and treatment until approximately thirty-four hours after the patient presented to the ED and developed chest pain. 4. Observations on 01/23/19 at 9:45 AM and on 01/30/19 at 5:15 PM revealed the facility provided Emergency Department (ED) services, and Surgical Services (services were limited to general surgery), and had a twelve (12) bed medical surgical inpatient unit. Chief Nursing Officer (CNO) on 01/30/18 at 6:20 PM and with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed the facility did not provide intensive/critical care services and had no policy/procedure in place regarding the scope of services that the medical surgical unit could provide. Subsequently, review of medical records revealed the facility admitted Patients #2, #8, and #11 (Patients #2 and #11 were admitted during the fourth quarter 2018; Patient #8 was admitted during the first quarter 2019) for treatment of diagnoses that the facility could not provide and a transfer to another facility was delayed. Patient #2 was admitted on 10/10/18 with a diagnosis of chest pain, to rule out a heart attack, even though the facility had no cardiologist on staff and no intensive care unit. Review of Patient #11's medical record revealed the patient was admitted to the facility on 09/20/18 with a consult for surgical services, even	A 273		

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A 273	Continued From page 65	A 273		

though the ED physician documented he was unsure if anesthesia services were available. On 09/21/18, the surgeon documented Patient # 11 should be transferred to another facility because he did not have the instruments or anesthesia available to treat the patient. However, the facility failed to transfer the patient until 09/24/18, three days later.

In addition, review of Patient #8's medical record revealed the facility directly admitted the patient from a physician's office on 01/21/18 with a diagnosis of Cerebrovascular Accident (CVA or stroke), even though the facility did not have a neurologist on staff, did not have an intensive care unit. In addition, interview with the Director of Pharmacy on 01/23/19 at 2:45 PM revealed the facility only had one vial of Activase. The pharmacist stated she had not had enough of the medication for several weeks, but was unable to order the medication due to the high cost and not enough money in the budget.

In addition, review of Patient #5's hip x-ray report completed on 11/27/18, revealed the patient had a fractured hip. However, there was no evidence the facility transported the patient for treatment of the hip fracture until 11/28/18.

Further, review of Patient #3's medical record revealed CT scans/angiograms on 12/31/18 revealed the patient had a blood clot in the femoral artery of the leg. The facility failed to transfer the patient to receive treatment for the blood clot until 01/01/19, and allowed the patient to go by private vehicle.

Review of the facility's Performance Indicators for 2018 revealed the facility monitored Case

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A 273	Continued From page 66 Management indicators that included the number of transfers to a facility that provided equal or a greater level of care and average length of stay. Review of the facility data for the fourth quarter of 2018 revealed four (4) patients had been transferred and the average length of stay was four days. There was no documented evidence that the facility identified any concerns with transfers and took any action to ensure patients were transferred timely. 5. Review of the facility's Performance Indicators for 2018 revealed the facility was required to monitor Radiology delays in service and call backs for radiology services; however, there was no data documented for the fourth quarter of 2018 and no documented evidence that the facility was monitoring performance in 2019. Review of Patient #12's medical record revealed the patient arrived at the facility's ED on 12/04/18 at 8:02 PM unresponsive and in full cardiac arrest (unconscious with no heart function or breathing) with cardio pulmonary resuscitation (CPR) in progress upon arrival. Review of physician orders for Patient #12 dated 12/04/18 at 9:10 PM, revealed the ED physician ordered Patient #12 to have a chest x-ray obtained "STAT" (immediately). However, review of Patient #12's medical record revealed no evidence the chest x-ray was obtained as ordered. Interview with Registered Nurse #13 on 01/30/19 at 2:30 PM revealed she could not state emphatically why Patient #12 did not get the chest x-ray as ordered, but stated there was no one from the Radiology Department present in the facility while Patient #12 was receiving treatment. Review of the Radiology Department's	A 273		

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A 273	Continued From page 67	A 273		

schedule confirmed that staff were not scheduled , but were on call from 12:00 AM until 7:00 AM; however, there was no evidence the facility was monitoring to ensure staff were providing timely services.

6. Review of Patient #4, #5, and #7's medical records and interview with the Dietary Manager on 01/24/19 at 11:10 AM revealed the facility failed to have a system for consulting the Registered Dietitian (RD). According to the Dietary Manager, staff did not consult the RD due to budget constraints.

Review of Patient #5's medical record revealed the patient was admitted on 11/26/18, with an order for a regular diet, and a weight of ninety-five pounds. However, further review of the record revealed the patient had a feeding tube and received no nutritional intake during the patient's admission from 11/26-28/18. There was no documented evidence the facility consulted the RD for Patient #5 to ensure the patient's nutritional needs were assessed and tube feeding was recommended to ensure the patient's needs were met.

In addition, review of Patient #7's medical record revealed the facility failed to ensure the RD consulted on Patient #7 who was admitted on 01/06/19 with a diagnosis of Cellulitis and a Stage 2 pressure sore.

Further, Patient #4 was admitted to the facility on 01/22/18 with a diagnosis of Diabetes. Review of the patient's physician orders revealed an order to administer insulin daily and an order to provide a no concentrated sweets diet. However, there was no documented evidence the facility

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A 273	Continued From page 68 administered the insulin on 01/22/19. In addition, observation on 01/23/19 at 4:30 PM revealed the resident was receiving a regular diet. There was no documented evidence the facility consulted the RD to assess Patient #4. Interview with the RD on 01/29/19 at 1:30 PM revealed he had only consulted on one patient in the approximately eight months that he had been contracted with the facility. Review of the facility's Performance Indicators for 2018 revealed the facility was required to monitor to ensure Registered Dietitian consultations occurred within forty-eight hours of being ordered; however, there was no data documented for the first, third, or fourth quarters, and there was an "x" in the second quarter. In addition, there was no documented evidence that staff were monitoring to ensure dietary consultations were completed in 2019. 7. Review of Patient #12's medical record revealed the patient presented to the ED on 12/04/18, in full cardiac arrest. On two different occasions, Patient #12 required multiple doses of Epinephrine (a medication to stimulate the heart) in an effort to sustain the patient's life. However, the facility failed to have enough medication to treat the patient, and medication had to be supplied to the facility by the Emergency Medical Services (EMS) that had transported the patient to the ED. Observation of the facility's ED on 01/30/19 at 5:00 PM revealed four (4) ampules of Epinephrine were available for an adult patient and four (4) ampules of Epinephrine for a pediatric patient. However, all eight ampules of Epinephrine had expiration dates of 01/31/19, the next day. Further, the facility had no available	A 273		

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A 273	Continued From page 69 Epinephrine to replace the expired Epinephrine and could not purchase any medication because their Pharmacy Distributor stopped releasing medication to the facility due to unpaid debt. Review of an audio recording dated 07/17/18, revealed EMS was attempting to transfer a patient to the ED who was exhibiting signs and symptoms of an acute stroke. However, when EMS contacted the ED to inform them that they were in route with the patient, they were informed by RN #11 not to bring the patient to the ED because they would "kill this guy." Subsequently, EMS contacted a transport helicopter and the patient was flown to another facility. Further, the facility had an "Acute Stroke Practice Standard for the Emergency Department" in place with specific criteria and interventions for the medical staff to follow and implement when a patient presented to the Emergency Department (ED) with signs/symptoms of a stroke. However, the facility failed to implement the standard of care on 11/12/18 at 10:35 AM, when Patient #10 presented to the ED with a "significantly elevated blood pressure" and exhibiting signs and symptoms of a stroke. The facility failed to implement their Acute Stroke Practice Standard for the Emergency Department, and subsequently, Patient #10 did not receive medical imaging including a non-contrast head computed tomography (CT) scan until after being admitted to the medical surgical floor and five (5) hours after arrival to the ED. In addition, the facility failed to administer Patient #10 the stroke scale assessment screening to determine the extent of deficits being experienced by the patient. On 11/12/18 at 4:20 PM, the results of a CT scan of the head for Patient #10 revealed the patient was	A 273		

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A 273	Continued From page 70 experiencing an apparent evolving infarct in the right parietal area. The patient was transferred to Facility #6 on 11/12/18 at 8:15 PM for treatment of an acute stroke. Observation and interview with the Director of Pharmacy on 01/23/19 at 2:45 PM, revealed the facility only had one vial of Tissue Plasminogen Activator (tPA) (name brand Activase), used to treat patients who were having a stroke. Interview with the pharmacist revealed the facility had been unable to purchase the medication in the past because of the high cost of the medication and the facility's budget constraints. However, as of 01/24/19, the facility did not have a Pharmacy Distributor from which to purchase any medication. Tours of the Emergency Department (ED) on 01/23/19 and 01/30/19 revealed the facility did not have a functioning telemetry monitor (shows the electrical activity of the heart) located at the nursing station, and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. Further observations revealed eight (8) of nine (9) rooms in the ED did not have a functional pulse oximeter (a device used to measures the amount of oxygen in the blood). Observations in the ED also revealed none of the nine (9) ED rooms contained a functional biohazard "sharps" container. Observation during the tour revealed the only biohazard "sharps" containers located in the ED were located in one hallway and another in the physician's charting room. Observations on 01/30/19 revealed ED staff had to transport used needles and devices through the hallway to get to a biohazard container to dispose of the items. In addition, observation of the casting room on	A 273		

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A 273	Continued From page 71 01/23/19 at 9:45 AM revealed it contained a limited number of supplies necessary to cast fractured bones of patients presenting to the ED in need of casting services. The ED's entire supply of casting tape was expired and the appropriate sizes were not available to treat various injuries. Further review of the facility's Key Performance Indicators for 2018 revealed the facility was required to monitor the elapsed time from entering the ED until the patient was first seen by a doctor, the percentage of patients admitted, and the percentage of patients receiving a Medical Screening Exam in the Emergency Department (ED). However, there was no documented evidence that the facility had been monitoring the care and services provided in the ED, even though the facility was aware needed medications, supplies, and equipment were not available to provide quality care and services. Further, there was no documented evidence any services provided in the ED were being monitored in 2019. Interview with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed that she had never discussed any quality of care issues with the governing body or the CEO. The COS stated the only conversations she had with the CEO were usually text messages about "When am I (the COS) going to get paid?" The COS stated she had never met the Governing Body of the facility. Continued interview with the COS revealed "at this point" she was not doing any type of chart reviews and had not been in the last six (6) months at least. The COS revealed the last Quality Meeting (Performance Improvement) she attended was in October 2018. She stated she	A 273		

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remembered a conversation surrounding Physician #1 performing the incorrect surgical procedure on a patient. However, she was never asked to review the medical record or to speak with Physician #1. Further interview with the COS revealed that she was unaware that the facility only had one (1) Activase vial. She stated she felt that as the COS, and an admitting physician, she should have been informed. The COS further stated that she was not aware the pharmacy had a list of medications that were unavailable and again felt like she should have been notified.

Interview with the Chief Nursing Officer (CNO) on 01/30/19 at 6:20 PM and with the Assistant Chief Nursing Officer (ACNO) on 01/30/19 at 6:20 PM revealed the facility had not had a Quality Meeting (Performance Improvement) since October 2018. The staff stated the Director of Quality Assurance/Performance Improvement (QAPI) resigned in July 2018 and since that time the facility had not been conducting QAPI activities. The CNO and ACNO stated they had not been reviewing nursing documentation for accuracy, physician orders to ensure they were followed, timeliness of medication administration, or other quality review of medical records. The CNO and ACNO stated they were busy with the budget and trying to keep the facility running.

Interview with a Former Governing Body Member on 01/30/19 at 2:07 PM, revealed that she was no longer employed by the facility's corporation and no longer functioned as a governing body member as of "last week." The Former Member stated that there was constant conversation about the facility's finances, and that the cash flow of the facility was always the topic of priority. She

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A 273	Continued From page 73 stated that she was not aware of a meeting or conversation she had attended or participated in regarding the facility that was not dominated by finances. The Former Member stated she was never involved in or aware of care concerns at the facility. Interview on 01/30/19 at 2:38 PM with the Chief Executive Officer (CEO) and Owner of the facility, revealed that the Chief Nursing Officer (CNO) and Chief Financial Officer (CFO) functioned as the onsite administration at the facility, and were responsible for the day to day operations. The CEO stated that he had reviewed the facility's quality assurance (QA) program a year ago, but was not aware that the QA Committee had not met since October 2018, and had not been identifying quality concerns in the facility. The CEO stated that he was unaware of any adverse events that had occurred at the facility and had never been informed or discussed that Emergency Medical Services had on occasion had to provide the facility with supplies and assist the ED staff with care of patients due to a shortage of staff and lack of supplies. (Refer to A0043, A0057, A0073, A0115, A0145, A0263, A0385, A0395, A0489, A0490, A0799, A0837, A0940, A0951, A0955, A1100, A1103, and A1104.)	A 273		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.	A 385		

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A 385	Continued From page 74 This CONDITION is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure nursing services were provided or supervised by a registered nurse. The facility failed to have a system for consulting the Registered Dietitian (RD) when patients had feeding tubes, pressure ulcers/wounds, or Diabetes and failed to have an effective system to ensure patients received physician ordered diets. The RD stated he had only consulted on one patient in the approximately eight months that he had been contracted with the facility. According to the Dietary Manager, staff did not consult the RD "because he charges $140.00 an hour and with the budget we have to operate on, we can't afford him." The facility failed to consult the RD for Patient #7 who had a diagnosis of cellulitis and a Stage 2 pressure sore or for Patient #4 who had a diagnosis of Diabetes and was not receiving/eating the ordered diet. In addition, the facility failed to ensure Patients #4 and #7 received diets as ordered by their physicians. Further, the facility did not have an effective system for ensuring Social Services was consulted. A consultation was recommended for Patient #7 who had no running water at home and did not have access to care and medications; however, a social services consultation was never completed and Patient #7 was discharged home. In addition, the facility failed to administer medications to Patients #4 and #7 as ordered by their physicians. Patient #7's medical record revealed the patient was admitted on 01/06/19 with Cellulitis to the right lower extremity (skin infection), early sepsis (a potentially	A 385	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated Governing Board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes (Controller) The facility failed to ensure nursing services were provided or supervised by a registered nurse. The nursing chain of command has been established as: RN Chief Nursing Officer to RN Assistant Chief Nursing Officer, to RN Charge Nurse and RN Charge Nurse/Supervisor. Indicators have been developed for the Charge Nurse and Shift Supervisors to do the daily chart audits. The facility failed to ensure an RN would supervise and evaluate the nursing care for each patient. Nursing staff will be in-serviced on Policy 200.241 on Continuum of Care Policy per ACNO. This will be verified by way of an in-service attendance log. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. (CNO)	2/22/2019 3/1/2019

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A 385	Continued From page 75 life-threatening condition caused by the body's response to an infection), and a Stage 2 pressure sore. The facility failed to administer Lovenox medication to prevent blood clots for patients as ordered by the physician and failed to ensure the pressure sore was assessed/treated. The facility also failed to ensure Patient #4's diuretic medication and potassium supplement were administered as ordered by the patient's physician, and failed to monitor and notify the patient's physician of the patient's urinary output.	A 385	For patient #4, the facility failed ensure the patient received the ordered diet. The facility failed to administer physician ordered medications and failed to complete a physician order. An electronic reflex process was put in place. The reflex is attached to questions on the flowchart and when nursing staff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dietician of the consult. A registered dietician (RD) was hired on 2/22/19. Diet orders were reviewed and verified by the RD. The reflex process was tested and verified during the 2/22/19 visit. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 700.240 Physician's Orders, policy 600.034 Medication Administration (Pharmacy), and 700.707 Medication Administration (Nursing). Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CNO/HR Director/RD) For patient #7, the facility failed to consult the RD and the patient did not receive the ordered diet. The facility failed to administer physician ordered medications and failed to ensure proper assessment and treatment pressure sore. The facility also lacked an effective system in which social services was consulted. An electronic reflex process was put in place. The reflex is attached to questions on the flowchart and when nursing staff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dietician of the consult. A registered dietian (RD) was hired on 2/22/19. Diet orders were reviewed and verified by the RD. The reflex process was tested and verified during the 2/22/19 visit. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 200.420 Skin Integrity, policy 200.403, Assessment and Reassessment of the patient, policy 200.606 Nursing Discharge, policy 700.701 Discharge Planning, policy 600.034 Medication Administration (Pharmacy), and 700.707 Medication Administration (Nursing). A reflex process has been initiated to notify the Social Services department of a consult. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on	2/22/2019 2/22/2019

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			medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CNO/HR Director/RD)	3/1/2019
			The reporting and follow up on medication errors was identified in the survey findings. The Medication Error Policy 600.085 has been in-serviced to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and MEC. This will be verified by the in-service attendance log. Licensed nursing staff will be in-serviced on policy 600.085, Medication Error. This will be verified by way of the in-service attendance log. Licensed nursing staff will be in-serviced on policy 600.085, Medication Error. This will be verified by way of an in-service attendance log. (ACNO)	3/1/2019
			The CEO was found to not be in compliance with overseeing all departments to ensure a good working relationship throughout the facility. CEO will oversee department managers and verify all hospital staff will be in-serviced on 700.708, Interdepartmental Relationships. Department by department updates will be discussed at weekly Managers meeting to promote interdepartmental cohesiveness. The Administrative Assistant will add this meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (CEO)	
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure nursing services were provided to supervise and evaluate the care of three (3) of twelve (12) sampled patients (Patients #4, #7 and #8). The facility failed to administer Lovenox (medication to prevent blood clots) for Patient #7 who was admitted on 01/06/19 with Cellulitis to the right lower extremity (skin infection), early sepsis (a potentially life-threatening condition caused by the body's response to an infection), and a Stage 2 pressure sore. The facility also failed to ensure staff assessed the pressure sore and failed to consult the facility dietitian as ordered by the physician. In addition, Patient #4 was admitted with	A 395	The facility failed to ensure nursing services were provided or supervised by a registered nurse. The nursing chain of command has been established as: RN Chief Nursing Officer to RN Assistant Chief Nursing Officer, to RN Charge Nurse and RN Charge Nurse/Supervisor. Indicators have been developed for the Charge Nurse and Shift Supervisors to do the daily chart audits. The facility failed to ensure an RN would supervise and evaluate the nursing care for each patient. Nursing staff will be in-serviced on Policy 200.241 on Continuum of Care Policy per ACNO. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. This will be verified by way of an in-service attendance log. (CNO)	3/1/2019 3/1/2019
			Nursing service should be able to identify patients who potentially need a referral. The CEO was found to not be in compliance with overseeing all departments to ensure a good working relationship throughout the facility. CEO will oversee department managers and verify all hospital staff will be in-serviced on 700.708, Interdepartmental Relationships. Department by department updates will be discussed at weekly Managers meeting to promote interdepartmental cohesiveness. The Administrative	

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A 395	diagnoses of Acute Congestive Heart Failure		Assistant will add this meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (CEO)	3/1/2019
			Indicators were added to QAPI program related to the IJ tags to monitor the procedures or processes that we have put in place to ensure that the plan is effective. This will be verified by the QAPI meeting minutes. (CNO)	2/22/2019
			For patient #4, the facility failed ensure the patient received the ordered diet. The facility failed to administer physician ordered medications and failed to complete a physician order. An electronic reflex process was put in place. The reflex is attached to questions on the flowchart and when nursing staff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dietician of the consult. A registered dietician (RD) was hired on 2/22/19. Diet orders were reviewed and verified by the RD. The reflex process was tested and verified during the 2/22/19 visit. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 700.240 Physician's Orders, policy 600 034 Medication Administration (Pharmacy), and 700 707 Medication Administration (Nursing). Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CNO/HR Director/RD)	

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A 395	Continued From page 76 (CHF) and Diabetes; however, the facility failed to provide a no-concentrated-sweet diet as ordered by the physician, failed to administer the patient's diuretic medication and potassium supplement as ordered by the patient's physician, and failed to monitor the patient's urinary output. Further, the facility failed to consult Social Services regarding Patient #7 who did not having running water or access to care, failed to provide the patient the physician ordered diet, and failed to consult the dietitian to assess the patient's wounds and diet. The findings include: Review of the facility policy titled "Medication Administration," dated August, 2017, revealed staff should provide care, treatment, and services using the most current physician orders. The policy stated the definition of "Now" when used with medication orders meant the medication should be administered within one (1) hour of the time the medication was ordered. The policy also stated early or late administration of some medications could have a significant or negative impact on the intended pharmacological or therapeutic effect of the medications, which included Anticoagulants, Antibiotics, and Insulins. Review of the facility's Skin Integrity/Pressure Ulcer policy, approved August 2018, revealed the purpose of the policy was to ensure all patients admitted to the facility were assessed for skin integrity. Review of the Plan for Assessment and Reassessment of Patients policy, approved February 2017, revealed patient assessments were initiated upon admission and continued throughout the patient's stay. The goal of patient	A 395	For patient #7, the facility failed to consult the RD and the patient did not receive the ordered diet. The facility failed to administer physician ordered medications and failed to ensure proper assessment and treatment pressure sore. The facility also lacked an effective system in which social services was consulted. An electronic reflex process was put into place to notify the dietary department of a consult. The reflex is attached to questions on the flowchart and when nursing staff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dietician of the consult. A registered dietian (RD) was hired on 2/22/19. Diet orders were reviewed and verified by the RD. The reflex process was tested and verified during the 2/22/19 visit. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 200.420 Skin Integrity, policy 200.403, Assessment and Reassessment of the patient, policy 200.606 Nursing Discharge, policy 700.701 Discharge Planning, policy 600.034 Medication Administration (Pharmacy), and 700.707 Medication Administration (Nursing). Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CNO/HR Director/RD) The reporting and follow up on medication errors was identified in the survey findings. The Medication Error Policy 600.085 has been in-serviced to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and MEC. This will be verified by the in-service attendance log. Licensed nursing staff will be in-serviced on policy 600.085, Medication Error. This will be verified by way of the in-service attendance log. Licensed nursing staff will be in-serviced on policy 600.085, Medication Error. This will be verified by way of an in-service attendance log. (ACNO)	2/22/2018 3/1/2019

Signature: _____ Date: 3/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

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A 395	Continued From page 77 assessment and reassessment was to determine the type and kind of care the patient required initially; also to determine the follow-up and response to that care, and frequent evaluations for changes in patient status and needs in order to change the plan of care. Review of the "Interdepartmental Relationships" policy, approved February 2017, revealed Nursing Services should identify patients who potentially needed a referral to some other agency or nursing facility after discharge, complete documentation as necessary for each referral, and notify Social Services when needs were identified. Further review of the policy revealed nursing staff should notify the dietitian of the need to consult on patients, and were required to coordinate the interdisciplinary plan of care with medical staff. Review of the facility's policy, "Diets/Meals," approved August 2018, revealed the purpose of the policy was to ensure timely and efficient provision of food and nourishment to patients. The policy did not address when a Registered Dietitian would be consulted. Interview with the Registered Dietitian (RD) on 01/29/19 at 1:30 PM revealed he had a contract with the facility to provide services and should be consulted to assess any patient with a pressure ulcer/wound, tube feeding, or a diagnosis of Diabetes. 1. Patient #7's medical record revealed the facility admitted the patient on 01/06/19 with diagnoses of Cellulitis to the right lower extremity and early sepsis. The patient was also admitted with a Stage 2 pressure sore to his/her right buttock.	A 395		

Signature: _____ Date: 3/1/19

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A 395	Continued From page 78 Review of Patient #7's admission orders dated 01/06/19 at 1:26 PM, revealed the patient's deep vein thrombosis (DVT/blood clot) prophylaxis, which consisted of a Lovenox (blood thinner) injection forty (40) mg twice daily. Physician orders dated 01/06/19 also revealed staff were required to document the following regarding the patient's Stage 2 pressure sore: the location, size, stage, depth, wound edges, any necrosis, amount of drainage, and condition of the surrounding tissue. A dietary consultation was also ordered when the patient was admitted on 01/06/19. Further review of Patient #7's medical record revealed staff did not administer Lovenox to the patient until 01/07/19 at 11:30 AM, approximately twenty-two (22) hours after the medication was ordered. In addition, there was no documented evidence that staff assessed the patient's pressure ulcer or consulted a dietitian as required by the patient's physician orders. Interview with Registered Nurse (RN) #2 on 01/24/19 at 2:30 PM and RN #4 on 01/24/19 at 12:40 PM revealed Lovenox was not available at the facility "at one time" but they could not recall the timeframe or if medication availability was a factor in Patient #4 not getting medication timely. Interview with the Registered Dietitian (RD) on 01/29/19 at 1:30 PM revealed he was not contacted to assess Patient #7. He stated staff should consult him to assess any patient who had a wound/pressure sore. However, the facility had only requested a consultation for one patient during the approximately eight months that he had been contracted with the facility.	A 395		

Signature: _____ Date: 3/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 395	Continued From page 79 2. Review of Patient #4's record revealed the patient was admitted to the facility on 01/22/19 with diagnoses of Acute Congestive Heart Failure (CHF), Generalized Weakness, and Diabetes. 2.a. Observation on 01/23/19 at 4:30 PM revealed Patient #4 was sitting in a chair eating dinner with family. Patient #4 was observed eating vanilla ice cream. Patient #4's daughter stated the patient was on a "regular" diet, even though the patient had a diagnosis of Diabetes. The daughter showed the surveyor the printed slip that accompanied the patient's meal from Dietary Services with the patient's name that read "regular" diet. Interview with Registered Nurse (RN) #2 on 01/23/19 at 4:40 PM revealed that Patient #4 was supposed to receive a no-added-salt and no-concentrated-sweets diet. RN #2 stated, however, that "it doesn't matter what diet is ordered, every patient up here gets the same food every meal." RN #2 stated he had not seen any specialized diets on the trays ever. Continued interview with Registered Nurse (RN) #2 on 01/27/19 at 5:00 PM and 01/29/19 at 5:00 PM revealed, "No one here gets a diet other than a regular diet, no matter what's ordered, or what diagnoses they have, even diabetics." Interview with the Dietary Manager on 01/24/19 at 11:10 AM revealed she doubled checked Patient #4's diet order in the computer and the order was entered into the computer "wrong." The Dietary Manager stated nursing staff had entered no added salt diet; however, they had put "no concentrated sweets" in the wrong section and dietary staff did not see the order. Continued interview with the Dietary Manager revealed that	A 395		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 395	Continued From page 80 even though "no concentrated sweets" was entered in the wrong place, dietary staff still should have seen the order or at least questioned the order. 2.b. Further review of Patient #4's medical record revealed the patient's physician wrote an order on 01/22/19 for staff to notify him of the patient's urine output over the next two (2) hours. RN #2 signed off the physician's order; however, there was no documented evidence that the RN monitored the patient's urine output two hours after admission or notified the physician of the patient's urine output. 2.c. Continued review of Patient #4's physician orders dated 01/23/19 at 8:15 AM revealed the physician prescribed Potassium twenty (20) milliequivalents (meq) by mouth "now" and discontinued the use of Intravenous (IV) Lasix (a diuretic medication that lowers potassium levels) forty (40) milligrams. However, review of Patient #4's Medication Administration Record (MAR) revealed Potassium was not administered to the patient until 5:17 PM on 01/23/19 (nine hours after the "now" order). Further, staff administered Lasix to the patient on 01/23/19 at 5:12 PM, even though the medication had been discontinued. Continued interview with RN #2 on 01/29/19 at 5:00 PM revealed he was unsure why he had not administered the patient's potassium "now" per the facility policy, or why he had not discontinued the patient's IV Lasix. The RN also acknowledged he had not notified the patient's physician of the patient's urine output as ordered. RN #2 stated, "I just f.. ed that up." 3. Review of Patient #9's medical record	A 395		

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

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A 395	Continued From page 81 revealed the facility admitted the patient on 01/16/19 with diagnoses that included venous stasis disease (slow blood flow in the veins to the legs) with cellulitis (infection) to both lower extremities. Review of Patient #9's admission assessment revealed the patient had weeping malodorous drainage from both lower extremities and the legs were "red with yellow crusty buildup to calf area bilaterally." According to the medical record, Patient #9 informed staff his/her condition had worsened because he/she had no running water at home, and had no transportation to get to/from scheduled physician appointments or to the pharmacy to get needed medications. Further review of Patient #9's medical record revealed on 01/16/19 at 5:30 PM a social services consultation was requested. However, further review revealed the facility discharged the patient home on 01/23/19, and there was no documented evidence that Adult Protective Services was ever contacted regarding the patient's inability to obtain medical care. Further review of physician orders dated 01/21/19, revealed Physician #5 ordered a "2 gm sodium diet" (2 days prior to the patient's discharge) for Patient #9. However, record review revealed the special diet order was not entered into the facility's computer system; subsequently, the Dietary Department did not provide a two gram sodium diet and the patient continued to receive a regular diet during the remainder of the hospital stay. There was no documented evidence that the Registered Dietitian was consulted for Patient #9,	A 395		

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A 395	Continued From page 82 and staff had not educated Patient #9 on the newly ordered diet. The patient was discharged home on 01/23/19 on a regular diet. Interview with the Registered Dietitian (RD) on 01/29/19 at 1:30 PM revealed he should have been asked to consult on Patient #9 to ensure the patient was receiving appropriate nutrition to heal the patient's wounds. Interview with the Dietary Manager on 01/24/19 at 11:10 AM revealed she was not a RD and even though the facility had a contract with a RD, she did not consult him related to inpatients' needs. The Dietary Manager stated even if patients had diet changes, pressure sores, or skin integrity impairments, she did not consult the RD "because he charges $140.00 an hour and with the budget we have to operate on, we can't afford him." Interview with Registered Nurse (RN) #2 on 01/27/19 at 5:00 PM revealed he discharged Patient #9 home on 01/23/19. He stated he had not reviewed the patient's record at the time of discharge and was unaware that Social Services had not been contacted. RN #2 also stated he was unaware that the patient did not have running water at home, or that he/she had no transportation to get to physician appointments or to obtain physician ordered medications. The RN further stated he was not aware Patient #9 had an order for a two gram sodium diet during the hospital stay. According to RN #2, "No one here gets a diet other than a regular diet, no matter what's ordered, or what diagnoses they have, even diabetics." Interview with the Assistant Chief Nursing Officer	A 395		

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A 395	Continued From page 83 (CNO) on 01/29/19 at 11:00 AM revealed medications should be administered as ordered and if physicians ordered social service consultations or diet changes, those orders should be followed. She also stated patients should be educated when special diets were ordered in the facility, and when applicable, the Registered Dietitian should be consulted. She also stated patients should be discharged home with diet instructions that had been ordered by the physician.	A 395		
A 489	Condition of Participation: Pharmaceutical Se CFR(s): 482.25 §482.25 Condition of Participation: Pharmaceutical Services. The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure pharmaceutical services were provided to meet the needs of patients. Interviews and review of emails revealed that effective 01/24/19, the facility did not have a Pharmacy Distributor to supply medications to the facility. According to the email, the retail pharmacy was "turning over the handling of outstanding amounts to our legal	A 489	The lack of consistent pharmaceutical supplies being received was identified in the survey. In order to ensure adequate supplies a pharmacy budget of $500,000 has been sent to the Controller. This will be verified by email sent to the Controller. (Controller) The supply of pharmaceutical supplies will be monitored by the QAPI plan which has been expanded to include "Percentage of medications requested on Omni restock with zero resupply to send versus the total number of medications requested. The Director of Pharmacy will monitor and report the compliance, and this will be verified by the weekly QAPI meeting minutes. (Director of Pharmacy) The reporting and follow up on medication errors was identified in the survey findings. The Medication Error Policy 600.085 has been in-serviced to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and MEC. This will be verified by the in-service attendance log (ACNO)	2/15/2019 3/1/2019 2/22/2019

Signature: _____ Date: 2/4/19

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A 489	Continued From page 84 team and will no longer be able to service the account." Observation, interview, and record review revealed the facility failed to have medications that were required by the facility's formulary; including antibiotics, intravenous fluids, and medications required for emergencies including Verapamil (used to treat high blood pressure, chest pain, and heart arrhythmia), Epinephrine (used to treat life threatening allergic reactions and cardiac arrest), and Sodium Bicarbonate (used in emergencies for cardiac arrest and metabolic acidosis). In addition, the facility only had one (1) dose of Activase (used to treat blood clots in patients having heart attacks and strokes). Interviews revealed the facility was unsure how they were going to obtain medications for use at the facility.	A 489	The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached. (CEO)	3/6/2019
			The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes. (Controller)	2/22/2019
A 490	Standard-level Tag for Pharmaceutical Service CFR(s): 482.25 Standard-level Tag for §482.25 Condition of Participation: Pharmaceutical Services. The hospital must have pharmaceutical services that meet the needs of the patients.. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to provide pharmaceutical services to meet the needs of patients consistent with the types of patients the facility serves. Interviews and review of emails revealed that effective 01/24/19, the facility did not have a Pharmacy Distributor to supply medications to the facility. According to the email, the distributor	A 490	The lack of consistent pharmaceutical supplies being received was identified in the survey. In order to ensure adequate supplies a pharmacy budget of $500,000 has been sent to the Controller. This will be verified by email sent to the Controller. (Controller)	2/15/2019
			The supply of pharmaceutical supplies will be monitored by the QAPI plan which has been expanded to include "Percentage of medications requested on Omni restock with zero resupply to send versus the total number of medications requested. The Director of Pharmacy will monitor and report the compliance, and this will be verified by the weekly QAPI meeting minutes. (Director of Pharmacy)	3/1/2019
			The reporting and follow up on medication errors was identified in the survey findings. The Medication Error Policy 600.085 has been in-serviced to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and MEC. This will be verified by the in-service attendance log (ACNO)	2/22/2019

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A 490	Continued From page 85 was "turning over the handling of outstanding amounts to our legal team and will no longer be able to service the account." Observation, interview, and record review revealed the facility failed to have medications that were required by the facility's formulary, including antibiotics, intravenous fluids, and medications required for emergencies. In addition, observation and interview revealed the facility's Verapamil and Epinephrine (drugs used in emergencies) expired on 01/31/18, and the facility only had one Activase (used to treat blood clots in patients having heart attacks and strokes). Interviews revealed the facility was unsure how they were going to obtain medications for use at the facility. In addition, Cardizem ER (medication used to treat high blood pressure, abnormal heart rhythms, and chest pain) was on the facility's formulary; however, the facility failed to ensure the medication was available. Patient #8 had an order for Cardizem ER; however, the facility failed to administer the medication because it was not available. In addition, Patient #8 had orders for Renvela (phosphate binding drug for patients with chronic kidney disease) and Biotin (water-soluble B vitamin); however, the medications were not on the formulary and the medications, or a substitute, were not administered to the patient. Patient #4 had physician orders to receive Victoza (an injectable diabetic medication) 6 milligrams (mg)/1 milliliter (ml) with the ordered dose of 1.2 mg to be administered daily. Interview with staff revealed the medication was not available; however, the facility failed to recognize that the patient was not getting any type of insulin. Subsequently, Victoza was not acquired for Patient #4 and a substitution was not	A 490	The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached. (CEO) The CEO was found to not be in compliance with overseeing the facility. The CEO will oversee the director of pharmacy to ensure that the pharmacist will review the patient medication lists to look for medications that were not available will occur on a prospective basis. The list of these medications will be taken to the P&T Committee for evaluation to determine the need to add to the formulary or for a therapeutic substitution. (Newly appointed CEO) The supply of pharmaceutical supplies was identified in the survey findings. The Director of Pharmacy will compile the list of backordered medications which will be forwarded to the charge/supervisor nurse for posting on each of the nursing units and in the emergency room. This will be verified by print-outs. The backordered medication lists will be presented to the P&T committee for discussion and planning of alternate solutions. This will be verified by the P&T committee minutes. (Director of Pharmacy)	3/6/2019 2/20/2019 and ongoing 2/15/2019

Signature: _____ Date: 3/4/19

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A 490	Continued From page 86 made to ensure the patient received insulin coverage for high blood sugar levels. The findings include: Review of the facility policy titled "Formulary System" dated July 2017, revealed the Pharmacy Department would provide a formulary of approved drugs assessed on the basis of need, effectiveness, risk, and cost to assure that medications were readily available for use within the hospital. The policy stated that physicians could also order medications that did not appear on the formulary. According to the policy, the pharmacist or pharmacy technician would attempt to obtain the item and would consult with the physician if the medication was unobtainable or if its procurement would be delayed. If these events occurred, the pharmacist would contact the physician for a "discontinue" or "substitute" order. The policy further revealed the Pharmacist "must communicate medication shortages, if they were to occur, to medical and nursing staff." Then the medical staff, through the Pharmacy and Therapeutics (P&T) Committee, were required to establish a formulary of medications for use within the hospital based on the shortages. According to the policy, the formulary would be reviewed at least quarterly within the hospital. 1.a. Review of Patient #4's record revealed the patient was admitted to the facility on 01/22/19 with Acute Congestive Heart Failure (CHF) and Generalized Weakness. Review of the record also revealed the patient's physician had ordered Victoza 1.2 mg, to be administered daily at 9AM. However, review of Patient #4's medication	A 490		

Signature: _____ Date: 3/4/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 490	Continued From page 87 administration record revealed the patient's 9:00 AM dose of Victoza for 01/23/19 was not administered. Review of the facility's formulary revealed Victoza was not listed on the formulary; however, other brands of insulin were available. Interview with Registered Nurse (RN) #2 on 01/23/19 at 4:40 PM revealed he had not administered Patient #4's Victoza medication because it was not available at the facility. RN #2 stated, "We've battled having medications that we need for a long time. Some things we can't provide to the patients, especially insulin pens. They won't buy them here, they're too expensive I guess." Interview with Patient #4's wife on 01/23/19 at 5:00 PM revealed the patient was frequently admitted to the facility including two (2) admissions "last month" in December 2018. She stated, "They don't have a lot of medications here that [the patients] are ordered to receive. I try to remember to bring the needed medications, but sometimes I forget." She stated if she forgot the medications, the patient "just has to go without them while we're here." There was no documented evidence that the pharmacist or technician attempted to obtain Victoza for the patient or contacted the patient 's physician for a substitution for the medication in accordance with the facility's policy. 1.b. Review of Patient #8's medical record revealed the facility admitted the patient on 01/22/19 with diagnoses of Acute Cerebrovascular Accident (CVA/stroke), Old CVA,	A 490		

Signature: _____ Date: 2/4/19

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A 490	Continued From page 88 and a recent fall with Concussion, Phosphatemia (presence of phosphate in the blood), Chronic Kidney Disease Stage 4, and a surgical history of a left nephrectomy (removal of a kidney). Further review of Patient #8's record revealed the patient was not oriented to person or place, and the patient was confined to bed. Review of Patient #8's physician orders dated 01/21/19 revealed orders to administer Cardizem ER one hundred eighty (180) milligrams (mg) twice daily, Renvela sixteen hundred (1600) mg three (3) times a days, and Biotin one thousand (1000) mg daily. Review of the facility's formulary revealed Cardizem 60 mg, 90 mg, and 120 mg tablets were listed as being available to administer at the facility. Further review revealed Renvela and Biotin were not listed. However, a review of Resident #8's Medication Administration Record (MAR) revealed Cardizem was not administered on 01/21/19 at 9:00 PM or on 01/22/19 at 9:00 AM as ordered. Further review revealed Renvela and Biotin were not administered on 01/22/19 at 9:00 AM as ordered. Staff had documented that the medications were "omitted because the medication was absent from the unit." The MAR also stated Biotin was "not on the formulary patient will need to bring own." There was no evidence the facility attempted to obtain Renvela and Biotin medications or notified the patient's physician that the medications were not available. Patient #8 was transferred from the facility on 01/22/19 and was unable to be interviewed.	A 490		

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A 490	Continued From page 89 Interview with Registered Nurse (RN) #3 on 01/22/19 at 8:20 PM revealed she cared for Patient #8 during the night shift (6 PM-6 AM) on 01/22/19, the night the patient was admitted. She stated the patient had physician orders for Cardizem; however, the medication was not available to be administered. According to RN #3, medication availability was a concern at times and she stated, "If the patients don't bring their home medications with them, they're not able to remain on them, or we have to substitute medications that they're not used to taking." Continued interview with RN #3 on 01/22/19 at 8:20 PM revealed nursing staff were not aware the facility was unable to provide patients with Cardizem ER, sixty (60) mg or ninety (90) mg. She stated "that would have been useful information." Interview with Physician #3 on 01/24/19 at 1:50 PM revealed he admitted patients to the facility and had not been notified that the facility was unable to provide Cardizem ER 60 mg or 90 mg to patients in the facility. According to Physician #3, the facility should have notified him of the inability to provide the medication so he could prescribe medications accordingly. Interview with Pharmacist #1 on 01/23/19 at 2:45 PM revealed "in the beginning of December" she removed all 60 mg and 90 mg Cardizem ER tablets from the facility because they were outdated. She stated there was a nationwide shortage of the medication and she was unable to obtain replacement medication, but had not notified physicians or licensed staff that the medication was not available at the facility.	A 490		

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A 490	Continued From page 90 Pharmacist #1 stated if physician ordered medications were not available, nursing staff was responsible for contacting the patient's physician for a substitute. The pharmacist stated she had conducted record reviews of inpatients at the facility and had not identified that patients were not receiving medications as ordered, due to the unavailability of medications. However, she then stated nursing staff were not documenting why medications had been omitted, but no attempts had been made to identify why patients had not received their ordered medications. She stated she had difficulty placing orders for medication with the current pharmacy vendor at times because the facility had consistently failed to make required payments on outstanding debt, which totaled approximately half a million dollars. Pharmacist #1 also stated the Pharmacy and Therapeutics Committee was required to meet quarterly, to discuss medication concerns in the facility, however, the Committee had not met since July 2018, a period of six (6) months. Review of the facility's Pharmacy and Therapeutics Committee Meeting Minutes revealed the Committee had not met since 07/18/18. Review of the 04/10/18 minutes revealed twenty-eight medications/Intravenous (IV) Solutions were listed as "drug shortages." There was no documentation regarding why there were drug shortages or what actions the facility took to obtain the medications/substitutes. Review of the 07/18/18 minutes revealed drug shortages were "unable to determine due to lack of drug orders being placed." 2. Observation of medications available in the Surgery Department on 01/23/19 at 11:00 AM revealed the following medications were not	A 490		

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A 490	Continued From page 91 available: Lidocaine (local anesthetic) 1%, 30 milliliter (ml) vials (par was for 8 vials); Diprivan (short-acting sedative used during surgical procedures; also used to sedate patients mechanically ventilated) 10 mg/ml, 50 ml vial (par was 35 vials); Diprivan 10 mg/ml, 100 ml vial (par was 20 vials); Ampicillin (antibiotic) 2 gm vial (par is 2); Atropine Sulfate (emergency drug for no or low heart rate) 1 mg/ml, 1 ml vial (par is 4); Bupivacaine/Epi .25% (local anesthetic) 30 ml vial (par is 10); Ancef (antibiotic) 1 gm (par is 6); Gentamicin (antibiotic) 80 mg/50 ml IV (intravenous) (par is 4); or Isovue (contrast used in CT scans) 300 (50 ml vial) (par is 6). In addition, the facility surgery department only had eight vials of Lidocaine 1% 10 mg/ml vial (par is 28 vials). Interview with Certified Registered Nurse Anesthetist (CRNA) #1 on 01/30/19 at 3:00 PM revealed the facility did not have the medications she preferred to use when anesthetizing patients. 3. Interview with the Director of Pharmacy (Pharmacist #1) on 01/23/19 at 2:45 PM revealed the facility pharmacy hours were from 7:00 AM to 3:30 PM. The Director of Pharmacy stated that if a new patient was admitted or a new medication was ordered after hours, staff were required to obtain the medication from the Omnicell (specialized medication dispensing cabinet). The pharmacist stated she stocked the Omnicells with medications before she left for the day. According to the Pharmacist, every Omnicell might not have every medication that was required, but the Omnicell in the Emergency Department had most of the medication that was available to the facility. Continued interview revealed she would come to the facility if needed	A 490		

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A 490	Continued From page 92 but stated she could not recall the last time she had been called back into the facility for that reason. Observation of facility medications in the Omnicell medication supply cabinet on 3 South (Medical Surgical Unit) on 01/25/19 at 12:30 PM revealed forty (40) medications were not available for administration after the pharmacy closed at 3:30 PM. Some of the medications that were not available included: Acetaminophen 325 mg (brand name Tylenol) (par level of 5); Amitriptyline 50 mg (antidepressant) (par level of 5 tablets); Diltiazem 100 mg injectable, 60 mg, 90mg or 120 mg tablets (brand name Cardizem treats high blood pressure/chest pain, heart arrhythmias); Levemir Insulin 100 units/1ML 10ML vial; Novolin R 100 units/1ML 10ML; Ondansetron Oral Disintegrating tablets (Zofran used to treat nausea) (par level of 10 tablets); Phenytoin 25 mg/1 ml 4 ml suspension (Dilantin used to treat and prevent seizures) (par level of 5); Sodium Bicarb 8.4% 50 ML syringe (used in emergencies for cardiac arrest and metabolic acidosis) (par level of 4 syringes); or Sodium Chloride 0.9% Flush 10 ML (used to flush intravenous (IV) lines) (par level of 100 syringes). Review of the Omnisupply on the Behavioral Health Unit dated 01/25/19 at 12:30 PM revealed eight medications were not available and on 3 West (Medical Surgical Unit) three medications were not available. Interviews with RN #7 on 01/24/19 at 3:10 PM, RN #4 on 01/24/19 at 5:20 PM, RN #3 on 01/22/19 at 8:20 PM, RN #2 on 01/24/19 at 1:50 PM, and with RN #11 on 01/29/19 at 6:45 PM revealed they never knew if the facility had	A 490		

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A 490	Continued From page 93 physician ordered medications available. The RNs stated when a medication was ordered, they had to "hunt" in every Omnicell in the facility to locate the medication, if they could find the medication at all. The RNs stated "hunting" for medications often caused a delay in treatment. Interview with Physician #5 on 01/29/19 at 4:30 PM revealed he practiced Internal Medicine at the facility and had for his entire medical career. Physician #5 stated that when the pharmacy notified him of some their inability to obtain medications due to their financial circumstances, he instructed his patients to bring their medications from home. Physician #5 acknowledged this was not the standard of practice for an acute care facility. Continued interview with Physician #5 revealed that he was not aware that the facility did not have Cardizem (a medication used to treat high blood pressure and chest pain). Physician #5 stated that he expected a phone call from the pharmacist telling him that certain medications were not available so he could make an informed decision about how best to proceed with care/prescribing medication. 4. Review of an email from Pharmacist #1 to the Chief Financial Officer (CFO) dated 01/18/19 at 2:03 PM revealed the pharmacist requested a pharmacy order that totaled $22,145.09 and stated "that still isn't enough of some things to last more than a week. When an order hasn't been received for 4 and 5 weeks this is the result-we have to have product to put back on the shelves." At 2:08 PM, on 01/18/19, the CFO responded to Pharmacist #1 that he had given the Chief Executive Officer (CEO)/owner $46,000 to wire to the Pharmacy Distributor.	A 490		

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A 490	Continued From page 94 However, review of an email from Pharmacist #1 to the Pharmacy Distributor's Advisor/Creditor dated 01/24/19 at 1:06 PM, revealed the she needed a narcotic order reinstated and released and needed two retail orders to be released. However, review of the Pharmacy Distributor's response dated 01/24/19 at 1:55 PM to Pharmacist #1 and to facility staff that included the pharmacist, the Chief Nursing Officer (CNO), and the CFO revealed the vendor would only release the orders if the facility wired $8,378.83 to cover an overdraft (bounced check), plus the cost of the new orders. According to the email, the Pharmacy Distributor would no longer release any more medications to the facility. The email stated, "Please be advised that these will be the last orders we will be able to release. After today, we will be turning over the handling of outstanding amounts to our legal team and will no longer be able to service the account." Further review revealed the CFO forwarded the response to the CEO and copied the CNO and Assistant CNO and stated, "One of the drugs we have on order with [the pharmacy distributor] is one of the drugs the state surveyor has asked if we have in stock. If we can't get this, we are likely to get a J-tag immediate jeopardy." Review of an email from Pharmacist #1 to the CEO, CFO, and CNO dated 01/25/19 at 8:38 AM revealed the facility's Vasopressin (used in cardiac arrest, shock, etc.) "expires in a couple of crash carts on 01/31/19. We have none in the pharmacy to replace this with. I have asked for this and the Activase to be ordered since 12/10/18. We need the 2nd Activase to be in the hospital to prevent any possible ER diversions	A 490		

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A 490	Continued From page 95	A 490		

due to lack of drug. $13,218.70 (Vasopressin + Activase)." The email further stated, "My narcotic order (from 1/18/19) was deleted due to the payment issues we have. I have no Demerol 25mg/ml in the pharmacy and only 13 vials in the hospital. I have less than 100 tabs of Norco 7.5/325mg in the pharmacy." According to the email, "Verapamil and Epinephrine need to be replaced on the crash carts before 1/31/19. I have none in the pharmacy to replace with...The [retail pharmacy vendor] note must be addressed and all holds off the accounts no later than Tuesday of next week to give me time to get these outdating drugs in and replaced. [Pharmacy Distributor's Advisor/Creditor] has indicated that he is no longer going to communicate with us and is turning the account over to legal. I don't know what this means for getting these and future orders released."

Further review revealed the CEO responded and stated, "So when we paid them $42,000 last week I thought we ordered a bunch of things...After this order how long will things last?" Pharmacist #1 responded with an email on 01/25/18 at 9:56 AM that stated the narcotic order was not released because the money was applied to the facility's debt. The email further stated, "The order did not contain the Activase or the Vasopressin that are needed (The $13K). These were not included on the last order due to the high cost. I wouldn't be sending an order this quick but we need the items that are outdated and narcotic orders...I hope you understand that this is not normal operating procedure for any pharmacy in this country. Pharmacy drug orders are sent daily everywhere else but at this facility and this was how we operated up until finances prevented this. My concern also is that [Pharmacy Distributor] is my

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A 490	Continued From page 96 only source of several drugs. I can't get them from anywhere else and [the distributor] has again cut us off and frozen the accounts." Review of the list of medications that Pharmacist #1 requested to be ordered on 01/25/19 at 12:30 PM revealed the following medications were not available at the facility: Acyclovir (antiviral) 5% ointment (par is two 5 gm tubes; Amiloride (used with other meds to treat high blood pressure, swelling due to heart failure or cirrhosis of the liver) HCL 5 mg tablets (par is 100 tablets); Amitriptyline (treats depression) HCL 50 mg tablets (par is 100 tablets); Amoxicillin (antibiotic) 250 mg/5 ml (par is 100 ml); Amoxicillin (antibiotic)/Potclavulanate 62.5 mg/5 ml (par is 75 ml); Azithromycin (antibiotic) 200 mg/5 ml (par is 30 ml); Epoetin Alfa-Epbx (treats low red blood cells) 40,000 U/ml (par is four 1 ml doses); Levofloxacin (antibiotic) 250 mg/50 ml (par is 24 bags), 500 mg/100 ml bags (par is 24 bags), or 750 mg/150 ml (par is 24 bags); or Moxifloxacin (antibiotic) HCL/0.8 % NACL 400 mg/250 ml (par is 12 bags). According to the email, the facility could not obtain Levofloxacin or Moxifloxacin from anywhere but the Pharmacy Distributor and stated, "have to have." Further review of the list of medications needed by the pharmacist included the following medications that were not available at the facility: Sodium Chloride 0.9% Irrigation (par is 12 1000 ml bags); Meperidine (Brand Name Demerol, pain medication) HCL 25 mg/ml (par is 25); Cyanocobalamin (Vitamin B12) 1000 mcg/ml (par is 25 doses); or Methylprednisolone Acetate (steroid) 40 mg/1 ml (par is 25 doses). According to the email, the facility only had 27 Sodium Bicarbonate (used in emergencies for cardiac	A 490		

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A 490	Continued From page 97 arrest and metabolic acidosis) 1 milliequivalent (meq)/ml (par is 10 doses). The email stated the medication was "used on crash carts can't run out." An interview was attempted with the Advisor/Creditor of the Pharmacy Distributor on 01/29/19 at 12:12 PM. A message was left to return the state agency's call. However, as of the exit date, 01/30/19, the vendor had not returned the state agency's call. Interview with the Director of Pharmacy on 01/29/19 at 11:00 AM revealed that she had sent an email to the CEO and the Pharmacy Distributor about needed medications, and the distributor referred her to their legal department. According to the Director of Pharmacy, the facility had no ability to obtain any more medications for the facility. She stated that to sign up with another Pharmacy Distributor would take eight (8) weeks or more. The pharmacist stated the CEO's plan to obtain medication since the distributor will no longer supply the facility, was to "borrow" medication from a facility he was attempting to purchase on 02/01/19 in Missouri; however, the pharmacist questioned the legalities of this "scheme." Interview with a Former Governing Body Member on 01/30/19 at 2:07 PM revealed she was no longer employed by the facility's corporation and no longer functioned as a governing body member as of "last week." The Former Member stated that she had been aware while functioning as a governing body member that the facility was having problems meeting financial obligations including obtaining medications. The Former Member stated that she knew the facility was on	A 490		

Signature: _____ Date: 2/11/19

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A 490	Continued From page 98 a payment plan with the Pharmacy Distributor, but was unaware that the pharmacy had stated they were going to stop supplying the facility with medication. The Former Member stated that communication about the facility was always concerning finances. The Former Member stated she had been aware that if needed supplies could not be obtained because of financial constraints, the CEO would contact the supplier and try to work out a deal. The Former Member stated when she was functioning as a governing body member, she was never informed that the facility was unable to obtain medications needed for patients. Interview on 01/31/19 at 2:38 PM with the Chief Executive Officer (CEO) and Owner of the facility revealed he was aware of concerns with obtaining medications at the facility. The CEO stated that the facility did have an outstanding balance owed to the Pharmacy Distributor, but stated the facility had paid down the debt considerably. The CEO stated the facility had a financial agreement with the distributor to pay on the outstanding debt while continuing to receive medications. However, the CEO stated that just recently the pharmacy distributor had refused to send medications to the facility and as of 01/24/19, the facility was unable to obtain medication from the pharmacy distributor. The CEO stated this was not the first time the pharmacy distributor had refused to supply medications to the facility, but as soon as a payment was made, they began supplying medications again. The CEO stated he was hopeful that the situation could be "worked out ASAP (as soon as possible)." The CEO went on to state that the corporation owned three other facilities, and if a patient was admitted to the facility and their ordered medication was not in	A 490		

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	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

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A 490	Continued From page 99 stock, the facility could "hopefully" borrow the medication from a sister facility located in another state (one located approximately 300 miles from the facility and the other located approximately 500 miles from the facility). The CEO stated that he was currently checking to see if "borrowing" medications and "transporting them over state lines" was permitted.	A 490		
A 799	DISCHARGE PLANNING CFR(s): 482.43 The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined that the facility failed to have an effective discharge planning process for one (1) of twelve (12) patients (Patient #9). On 01/16/19 at 5:30 PM, a social services consultation was requested for Patient #9 because the patient did not have running water at home and did not have transportation to/from appointments or the pharmacy. However, the facility failed to conduct a social services consultation and discharged Patient #9 home on 01/23/19.	A 799	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes. **(Controller)** The facility did not have an effective system for ensuring social services was consulted. A reflex was attached to questions in flowchart pertaining to social services. When nursing staff choose answers to questions, it sends an electronic trigger to social services department and staff. Licensed nursing staff will be in-serviced on policy 200.206 Nursing Discharge Planning, and policy 700.701, Discharge Planning by Case Management. This will be verified by the in-service attendance log. Med/Surg and the ED will continue to keep a paper log of the referrals. The staff will be in-serviced on this process. This will be verified by way of an in-service attendance log. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. **(Case Management Director)** The CEO was found to not be in compliance with overseeing all departments to ensure a good working relationship throughout the facility. CEO will oversee department managers and verify all hospital staff will be in-serviced on 700.708, Interdepartmental Relationships Department by department updates will be discussed at weekly Managers meeting to promote interdepartmental cohesiveness. The Administrative Assistant will add this	3/1/2019 2/18/2019 3/1/2019

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A799		A799	meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (CEO) New indicators were added to QAPI program related to the social services consultations and discharge consultations to monitor the procedures or processes that we have put in place to ensure that the plan is effective. This will be verified by the QAPI meeting minutes. (Discharge Planner)	Monthly
A 837	TRANSFER OR REFERRAL CFR(s): 482.43(d) The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. This STANDARD is not met as evidenced by: Based on interview, record review, and review of	A 837	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes. (Controller) The facility did not have an effective system for ensuring social services was consulted. A reflex was attached to questions in flowchart pertaining to social services. When nursing staff choose answers to questions, it sends an electronic trigger to social services department and staff. Licensed nursing staff will be in-serviced on policy 200.206 Nursing Discharge Planning, and policy 700.701, Discharge Planning by Case Management. This will be verified by the in-service attendance log. Med/Surg and the ED will continue to keep a paper log of the referrals. The staff will be in-serviced on this process. This will be verified by way of an in-service attendance log. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. (Case Management Director)	3/1/2019 3/1/2019

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN KY MEDICAL CENTER	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

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A 837	Continued From page 100 facility policy, it was determined that the facility failed to ensure one (1) of twelve (12) patients (Patient #9) was referred to appropriate agencies for follow-up. On 01/16/19 at 5:30 PM, a social services consultation was requested for Patient #9 because the patient did not have running water at home and did not have transportation to/from appointments or the pharmacy. However, the facility failed to conduct a social services consultation and discharged Patient #9 home on 01/23/19. The findings include: Review of the Discharge Planning policy dated August 2018, revealed discharge planning as well as discharge teaching should focus on current needs and anticipated needs based on the reason for hospitalization. Review of the "Interdepartmental Relationships" policy, approved February 2017, revealed Nursing Services should identify patients who potentially needed a referral to some other agency or nursing facility after discharge, complete documentation as necessary for each referral, and notify Social Services when needs were identified. Review of Patient #9's medical record revealed the facility admitted the patient on 01/16/19 with diagnoses that included venous stasis disease (slow blood flow in the veins to the legs) with Cellulitis (infection) to both lower extremities. Review of Patient #9's admission assessment revealed the patient had weeping malodorous drainage from both lower extremities and the legs were "red with yellow crusty buildup to calf area bilaterally."	A 837	The CEO was found to not be in compliance with overseeing all departments to ensure a good working relationship throughout the facility. CEO will oversee department managers and verify all hospital staff will be in-serviced on 700.708, Interdepartmental Relationships. Department by department updates will be discussed at weekly Managers meeting to promote interdepartmental cohesiveness. The Administrative Assistant will add this meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (CEO) For patient #9, the facility lacked an effective system in which social services was consulted. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 200.606 Nursing Discharge, policy 700.701 Discharge Planning. A reflex was attached to questions in flowchart pertaining to social services. When nursing staff choose answers to questions, it sends an electronic trigger to social services department and staff. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CNO/HR Director/RD) New indicators were added to QAPI program related to the social services consultations and discharge consultations to monitor the procedures or processes that we have put in place to ensure that the plan is effective. This will be verified by the weekly QAPI meeting minutes. (Discharge Planner)	3/1/2019 2/22/2019 Monthly

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A 837	Continued From page 101 According to the medical record, Patient #9 informed staff his/her condition had worsened because he/she had no running water at home, and had no transportation to get to/from scheduled physician appointments or to/from the pharmacy to get needed medications. Further review of Patient #9's medical record revealed on 01/16/19 at 5:30 PM a social services consultation was requested. The facility discharged the patient home on 01/23/19, and there was no documented evidence that Adult Protective Services was ever contacted regarding the patient's inability to obtain medical care. Interview with Registered Nurse (RN) #2 on 01/27/19 at 5:00 PM revealed he discharged Patient #9 home on 01/23/19. He stated he had not reviewed the patient's record at the time of discharge and was unaware that Social Services had not been contacted. RN #2 also stated he was unaware that the patient did not have running water at home, or that he/she had no transportation to get to physician appointments or to obtain physician ordered medications. Interview with the Assistant Chief Nursing Officer (CNO) on 01/29/19 at 11:00 AM revealed if social services consultations were recommended, the consultation should be completed.	A 837		
A 940	SURGICAL SERVICES CFR(s): 482.51 If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are	A 940		

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A 940	Continued From page 102 offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: Based on interviews, record reviews, review of a facility policy, and review of a facility investigation, it was determined the facility failed to ensure well-organized surgical services were provided in accordance with acceptable standards of practice. Observations and interviews with staff revealed the facility failed to maintain surgical equipmentin working order, failed to have formulary medications available for sedation and emergencies, and failed to ensure cleaner/disinfectant used to clean/sanitize surgical instruments and operating rooms was not expired. In addition, on 08/16/18, Patient #1 was admitted for abdominal pain and signed a consent to have an Esophagogastroduodenoscopy (EGD) (a procedure to examine the stomach and upper portion of the small intestine). However, review of the "Operating Room Nurses Note" and a facility investigation revealed the facility attempted to perform a colonoscopy (a procedure to examine the colon from the rectum) and performed a sigmoidoscopy (examined the inner part of the rectum and lower colon) without the patient's consent.	A 940	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes. (Controller) The facility had failed to maintain surgical equipment in working order. A maintenance contract, with DC Services (2/2019) is in place to service Steris equipment/autoclaves Backup equipment is readily available. This will be verified by a daily maintenance log of Steris and autoclave equipment. All equipment has been verified by either by DC Services, MedTech, or PMD services and is up to date as of 2/2019. (Surgery Charge Nurse) The facility was found to not be in compliance because the CEO did not ensure the conduct of the facility was in compliance. As a result, the facility did not ensure the staff were following proper procedure in obtaining the proper informed consent for patient #1 on 8/16/18. To prevent this issue from reoccurring, the CEO will oversee the CNO who will ensure the Surgery Charge Nurse, surgical staff and physicians are in-serviced on the Informed Consent policy, 700.223, and policy 700.003 on Verification of Correct Site, Correct Procedure and Correct Patient for Invasive or Surgical Procedures. This will be verified by the in-service attendance log. A new QAPI performance indicator has been added to the weekly QAPI process to monitor this measure. The OR circulator uses the surgery checklist tool to verify the informed consent has been completed prior to the procedure. The OR Charge Nurse will also review the checklist that was completed by the circulator prior to procedure, and if any problems identified, they will be corrected prior to procedure being completed, logging results to report to QAPI weekly. This will be verified by the in-service attendance log. (CEO) The lack of consistent pharmaceutical supplies being received was identified in the survey. In order to ensure adequate supplies a pharmacy budget of $500,000 has been sent to the Controller. This will be verified by email sent to the Controller. (Controller) The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being	2/22/2019 2/28/2019 3/1/2019 2/15/2019 3/6/2019

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			available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached **(CEO)**	
			Material supply issues were identified in the survey findings. The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility staff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ae replaced now through weekly orders to our materials supply vendor. **(CEO)**	2/22/2019
A 951	OPERATING ROOM POLICIES CFR(s): 482.51(b) Surgical services must be consistent with needs and resources. Policies governing surgical care	A 951	Diversey was contacted on 1/24/2019 regarding manufacturer date and expiration date of Virex Tb by the Housekeeping Supervisor via phone. Diversey responded with an email stating that "the date on the product was the manufactured date, not the expiration date and if Diversey puts an expiration date on their products, the number is proceeded with EXP." The products in question were manufactured 5/14/2018 and have a shelf life of 3 years. The Surgery staff has been in-serviced on policy 900.001 Expired materials. This can be verified by the in-service attendance log. **(Housekeeping Director/Surgery Charge Nurse)**	1/24/2019
			The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes. **(Controller)**	2/22/2019
			The facility had failed to maintain surgical equipment in working order. A maintenance contract,with DC Services (2/2019) is in place to service Steris equipment/autoclaves. Backup equipment is readily available. This will be verified by a daily maintenance log of Steris and autoclave equipment. All equipment has been verified by either by DC Services, MedTech, or PMD services and is up to date as of 2/2019. **(Surgery Charge Nurse)**	2/28/2019

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A 951	Continued From page 103 must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and review of facility policies it was determined the facility failed to provide surgical services consistent with needs and resources and designed to ensure the achievement and maintenance of high standards of medical practice and patient care. Observations and interviews with staff revealed the facility failed to maintain surgical equipment in working order, failed to have formulary medications available for sedation and emergencies, and failed to ensure cleaner/disinfectant used to clean/sanitize surgical instruments and operating rooms was not expired. The findings include: Review of the facility policy titled, "Reporting Equipment Failures or Malfunctions," revised January 2018, revealed all known or suspected equipment failures or malfunctions would be reported to the Facility's Management Department. Continued review of the policy revealed if the equipment was needed for the immediate care of a patient, attempts would be made to find an alternate type of equipment, borrow equipment from another facility, or obtain equipment from a rental company or loaner from the equipment supplier. Further review of the policy revealed if the patient was undergoing a procedure, the physician would make the decision to terminate, reschedule, or transfer the patient to another facility.	A 951	The lack of consistent pharmaceutical supplies being received was identified in the survey. In order to ensure adequate supplies a pharmacy budget of $500,000 has been sent to the Controller. This will be verified by email sent to the Controller. (Controller) The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached (CEO) Material supply issues were identified in the survey findings. The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility staff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies are replaced now through weekly orders to our materauls supply vendor. (CEO) All employees and providers will be in-serviced on "Chain of Command" Policy 200.107. In-service will be initiated 2/22/2019. This will be verified by the in-service attendance log. (ACNO)	2/15/2019 3/6/2019 2/22/2019 3/1/2019

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A 951	Continued From page 104 1. Review of the Operating Room Schedule for Facility #1 dated 01/17/19 revealed Patient #6 was scheduled for a Colonoscopy with Physician #3. Interview with the Peri-Operative Charge Nurse on 01/22/19 at 4:30 PM revealed in the past surgeries and procedures had to be cancelled due to equipment not being in good repair or working order. The Charge Nurse stated that Physician #3 had to reschedule Patient #6's colonoscopy because the Steris Machine was broken and the facility had no capability to clean the scope used for a colonoscopy. The Charge Nurse stated that due to the facility having an outstanding debt with the vendor, the vendor would not repair the machine until the facility pre-paid for their services. Interview with Physician #3 on 01/24/19 at 1:50 PM revealed he was the Director of Surgical Services at the facility. Physician #3 stated he was scheduled to perform Patient #6's colonoscopy the day the Steris Machine was "down." Physician #3 stated he was not aware that had the facility had the funds, the machine could have been repaired in enough time to perform the colonoscopy for Patient #6. Physician #3 stated he instructed the facility to have the patient go to another facility where he had privileges and could do the colonoscopy. Continued interview revealed that he was aware of the facility's financial issues, and stated it impeded the ability to provide quality services at times. Physician #3 used the example of the Steris Machine. He stated most facilities would have it repaired prior to procedures being affected. However, at this facility, because of money problems, the vendor will not come unless	A 951	Diversey was contacted on 1/24/2019 regarding manufacturer date and expiration date of Virex Tb by the Housekeeping Supervisor via phone. Diversey responded with an email stating that "the date on the product was the manufactured date, not the expiration date and if Diversey puts an expiration date on their products, the number is proceeded with EXP." The products in question were manufactured 5/14/2018 and have a shelf life of 3 years. The Surgery staff has been in-serviced on policy 900.001 Expired materials. This can be verified by the in-service attendance log. (Housekeeping Director/Surgery Charge Nurse)	1/24/2019

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A 951	Continued From page 105 the facility pays upfront, resulting in a wait time. Interview with Maintenance Technician #2 on 01/23/19 at 2:00 PM revealed the Steris Machine was "out" last week and could not be repaired because the facility owed the vendor "a lot of money." He stated the vendor was contacted but refused to come without payment in advance. The Maintenance Technician stated he was not qualified to repair the machine. Review of the medical record for Patient #6 from Facility #3 revealed Facility #3 admitted Patient #6 on 01/17/19 with a complaint of rectal bleeding. Physician #3 performed a Colonoscopy on Patient #6 without issue and the patient was discharged home the same day. 2. Observation of medications available in the Surgery Department on 01/23/19 at 10:15 AM revealed the following medications were not available: Lidocaine (local anesthetic) 1%, 30 milliliter (ml) vials (par was for 8 vials); Diprivan (short acting sedative used during surgical procedures; also used to sedate patients mechanically ventilated) 10 milligrams/milliliter (mg/ml), 50 ml vial (par was 35 vials); Diprivan 10 mg/ml, 100 ml vial (par was 20 vials); Ampicillin (antibiotic) 2 gm vial (par is 2); Atropine Sulfate (emergency drug for no or low heart rate) 1 mg/ml, 1 ml vial (par is 4); Bupivacaine/Epi .25% (local anesthetic) 30 ml vial (par is 10); Ancef (antibiotic) 1 gm, (par is 6): Gentamicin (antibiotic) 80 mg/50 ml IV (intravenous) (par is 4); or Isovue (contrast used in CT scans) 300 (50 ml vial) (par is 6). In addition, the facility surgery department only had eight vials of Lidocaine 1% 10 mg/ml vial (par was 28 vials).	A 951		

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A 951	Continued From page 106 Interview with Registered Nurse (RN) #13 on 01/30/19 at 1:50 PM revealed staff had to leave the Operating Room at times to obtain needed supplies to continue surgeries. Continued interview with RN #13 revealed the facility also had to cancel surgeries due to malfunctioning equipment or not having the appropriate supplies on hand. Interview with Certified Registered Nurse Anesthetist (CRNA) #1 on 01/30/19 at 3:00 PM revealed the facility did not have the medications she preferred to use when anesthetizing patients. She stated the last time she was at the facility approximately one month ago, the facility had "a big vial" of Diprivan, which was "wasteful" as most of the medication had to be thrown away because it was not used on the patient. Interview with the Chief Financial Officer (CFO) on 01/28/19 at 6:00 PM revealed he managed the facility's finances and was in contact with the Chief Executive Officer frequently regarding the financial situation of the facility. The CFO stated the Pharmacy Distributor would no longer provide medications to the facility due to an outstanding debt of $500,000 and would only speak to the facility through the distributor's attorney. According to the CFO, the facility had no plans on paying the Pharmacy Distributor and it would take approximately eight (8) weeks to obtain another Pharmacy Vendor. The CFO stated the CEO's plan was to attempt to borrow medication from a "sister" facility that the CEO was attempting to purchase in Missouri. 3. Observation during tour on 01/23/19 at 10:50 AM of the sterile processing area revealed three (3) bottles of the Virex TB (an all-purpose,	A 951		

Signature: _____ Date: 3/1/19

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A 951	Continued From page 107 hospital-grade cleaner, sanitizer, and disinfectant) available for use for cleaning surgical instruments prior to being sterilized. Two (2) bottles expired on 05/14/18 and one bottle expired on 08/10/18. Further observation of three (3) Virex TB bottles in storage revealed they also expired on 05/14/18. Observation in central supply on 01/23/19 at 10:55 PM revealed fourteen (14) bottles of Envy Disinfectant Cleaner with an expiration date of 06/14/18. Interview with the manufacturer of Virex TB and Envy on 01/23/19 at 11:35 AM revealed the date that was stamped on the bottles was the expiration date of the product. The manufacturer stated it was not recommended to be used in a health care setting past the expiration date. Interviews with Sterile Processing Technician #1 on 01/23/19 at 10:55 AM and with Sterile Processing Technician #2 on 01/23/19 at 11:00 AM revealed they were unaware the Virex TB bottles were expired. Continued interviews revealed they had to "hide" cleaner from the rest of the facility in order to keep from running out. The technicians stated they thought the Virex TB solution came from a facility in another state that had closed. Further interviews revealed the technicians ran out of biological indicators (an indicator is placed in each item to be sterilized and it provides information on whether necessary conditions were met to provide a level of confidence in the process) in December 2018 and were not able to sterilize any instruments for approximately a week. The technicians stated they were fearful it would happen again.	A 951		

Signature: _____ Date: 2/14/19

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A 951	Continued From page 108 Interview with the Director of Housekeeping on 01/23/19 at 11:10 AM revealed Virex TB and Envy cleaners were also used to disinfect the Operating Room, Emergency Department, and all patient care areas. The Director was unaware the cleaner was expired. Interview with the Chief Nursing Officer (CNO) on 01/23/19 at 2:30 PM revealed at times the facility orders supplies but the supplies were shipped to another state, to another facility owned by the CEO (Chief Executive Officer). Continued interview revealed the CEO had also instructed staff to obtain supplies from a facility in another state that had "been closed for a while." The CNO stated the disinfectants probably came from that facility and that is why they were expired. Interview with Physician #9 on 01/30/19 at 11:00 AM revealed he left Southeastern KY Medical Center in October 2018 because he felt continuing to provide care in the facility was "endangering the lives of my patients" because there was not adequate equipment or supplies in the facility. He stated he had scheduled two patients for laparoscopic cholecystectomies (removal of the gall bladder) in "mid October" but was notified that the facility was unable to sterilize instruments. He stated he had to call the call the patients and tell them that he was unable to do their surgery as scheduled. Further interview with Physician #9 revealed availability of supplies was also a concern at the facility. He stated that there had been times during surgical procedures when staff had to leave the Operating Room to go search the hospital for sterile gauze or tape because the facility was unable to keep the rooms adequately stocked. Physician #9 also stated medication availability was a concern. He	A 951		

Signature: _____ Date: 3/4/19

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A 951	Continued From page 109 stated he was constantly forced to change antibiotic orders because they were not available, which caused a delay in patient's antibiotic treatment. Physician #9 stated he had a patient who presented to the ED with a "completely blocked colon," which required emergency surgery, and a critically low white blood count (WBC) of 0.8. He stated that without his knowledge, the hospital had stopped stocking the medication the patient needed to "stimulate the bone marrow" to produce more blood cells. He stated "they had to go searching to area hospitals until they were able to obtain the needed medication, which wasn't provided to the patient until late in the night." According to Physician #9, he was "unsure how a surgical department was functioning without propofol [Diprivan]" because the medication was frequently used in the surgical setting.	A 951		
A 955	INFORMED CONSENT CFR(s): 482.51(b)(2) A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies. This STANDARD is not met as evidenced by: Based on interviews, record reviews, review of a facility policy, and review of a facility investigation, it was determined the facility failed to execute an informed consent for one (1) of twelve (12) sampled patients (Patient #1) prior to a procedure in the surgery department. On 08/16/18, Patient #1 was admitted for abdominal pain and signed a consent to have an Esophagogastroduodenoscopy (EGD) (a procedure to examine the stomach and upper	A 955	The facility failed to execute an informed consent for one of twelve sample patients (patient #1) in the surgery department. To prevent this issue from re-occurring, the CEO will oversee the CNO who will ensure the Surgery Charge Nurse, surgical staff and physicians are in-serviced on the Informed Consent policy, 700.223, and policy 700.003 on Verification of Correct Site, Correct Procedure and Correct Patient for Invasive or Surgical Procedures, and Surgical Checklist and Site Verification Checklist. This will be verified by the in-service attendance log. A peer review was conducted by the chief of surgery and chief of staff on 2/21/19 and now the checklist is completed prior to the procedure and surgical site verification criteria is also completed prior to the procedure, checklist attached. A new performance indicator has been added to the QAPI dashboard. Through chart reviews, data will be collected to verify informed consents. The surgery charge nurse will report this to QAPI weekly. This will be verified by the in-service attendance log. (CEO)	3/1/2019

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A 955	Continued From page 110 portion of the small intestine). However, review of the "Operating Room Nurses Note" and a facility investigation revealed the facility attempted to perform a colonoscopy (a procedure to examine the colon from the rectum) and performed a sigmoidoscopy (examined the inner part of the rectum and lower colon) without the patient's consent. The findings include: Review of the facility policy titled, "Verification of Correct Site, Correct Procedure and Correct Patient for Invasive or Surgical Procedures," approved June 2017, revealed the facility must complete the following steps before every invasive or surgical procedure: confirmation of the correct procedure and patient shall occur in pre-procedure/pre-operative area, involving the patient whenever possible and completing a "time out" for all cases. Continued review of the policy revealed time outs would be performed before all surgical or invasive procedures. Further review of the policy revealed the facility defined a "time out" as the pause in patient care activity conducted by the surgical team immediately before starting the procedure to conduct a final assessment that the correct patient, site, positioning, and procedure are identified and that all relevant documents, related information, and necessary equipment are available. According to the policy, time outs will cause all other activities to be suspended; will be initiated by a designated Registered Nurse circulator; will involve all members of the surgical team; and will address the correct patient, correct side/site marked, consent form present and accurate; agreement on the procedure to be done; correct patient position; and reconcile problems if theresponses	A 955		

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A 955	Continued From page 111 among team members differ. Review of Patient #1's medical record revealed the facility admitted the patient on 08/16/18. Review of Patient #1's History and Physical (H&P) dated 08/15/18 and updated on 08/16/18 at 12:00 PM, revealed Patient #1's chief complaint was "[Shortness of Breath], Hepatitis C, Vomiting and Abdominal Pain." There was no documented Impression/Diagnosis or plan. Review of the "pre-admission order sheet" dated 08/16/18 revealed Patient #1 was diagnosed with Abdominal Pain and the pre-surgical orders were: Pre-op medications as instructed by the surgeon's office and prep as indicated for colonoscopy. However, review of an Informed Consent form revealed Patient #1 consented for an EGD on 08/16/18 at 11:55 AM, not a colonoscopy. In addition, Physician #1 signed the informed consent form for an EGD on 08/16/18 at 12:00 PM. Review of Patient #1's "Pre Anesthesia Assessment," dated 08/16/18 at 12:16 PM revealed the "proposed procedure" was an EGD. Review of the "Anesthesia Record," dated 08/16/18, also revealed the patient was having an EGD. According to the Anesthesia Record, anesthesia was initiated for Patient #1 on 08/16/18 at 12:56 PM for an EGD and a "Time Out" was conducted at 12:57 PM. The record revealed anesthesia was stopped at 1:04 PM and the patient was taken to the Post-Anesthesia Care Unit (PACU). Review of the Comprehensive Surgical Checklist dated 08/16/18 for Patient #1 revealed staff documented that the RN confirmed with the	A 955		

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A 955	Continued From page 112 patient the patient's identity, the procedure, and the consent. Staff also documented a time out was conducted and confirmation of the patient's identity, procedure, and consent was conducted. Review of the "Operating Room Nurses Note" dated 08/16/18 also stated Patient #1 was identified by name, birthdate, chart, and operative consent. However, continued review of the note revealed Patient #1 was taken in the OR room at 12:56 PM and an "Active Time Out" was conducted at 12:57 PM and the procedure "Flexible Sigmoidoscopy" was verified, not an EGD, the only procedure to which the patient consented. Review of a facility "Variance Report Investigation" dated 08/16/18 revealed Patient #1 was taken into the Operating Room and a colonoscopy was attempted. Due to "poor prep," a flex sigmoidoscopy was done and Patient #1 was transported to PACU. The Investigation stated that Physician #1 spoke with Patient #1's family member and informed them the patient had a "poor prep." The family informed Physician #1 that the patient was scheduled for an EGD, not a colonoscopy. According to the investigation, Physician #1 brought the patient's record to staff who reviewed the patient's medical record and upon review of the surgical consent, history and physical, and physician orders, it was determined the attempted colonoscopy was "performed in error." According to the investigation, the RN "believes" he initiated the time out procedure and stated the procedure was supposed to be an EGD; however, the room had been set up with equipment for a colonoscopy and "with no objections from any team members an attempted colonoscopy was performed." The	A 955		

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A 955	Continued From page 113 investigation revealed the OR technician stated that the time out was conducted; however, staff stated the patient was supposed to have a colonoscopy. The CRNA initially stated the RN conducted the time out and stated the procedure was supposed to be a colonoscopy, then the CRNA changed her mind and said it was supposed to be an EGD. Further review of the investigation revealed all staff involved stated a "time out" was conducted, but they made conflicting statements about which procedure was announced. Further review revealed the OR room was set up for a colonoscopy. The investigation stated Patient #1 was then taken back to the OR suite and an EGD was performed without incident. Interview with Peri-Operative Charge Nurse on 01/24/19 at 3:55 PM revealed she was notified of the incident with Patient #1 on 08/16/18. She stated she notified Administration and began an immediate investigation. The Charge Nurse stated that the OR room was prepped for a colonoscopy, not for an EGD. She further stated that she interviewed the circulating nurse, the two surgery technicians (CST) that were present in the OR, and the Certified Registered Nurse Anesthetist (CRNA), who stated a "time out" was conducted. The Circulating Nurse and CRNA stated they announced an EGD; however, neither stopped Physician #1 from performing the colonoscopy. According to the Charge Nurse, she re-educated staff regarding the time out process; however, Physician #1 refused to discuss the incident and the Director of Surgery refused to re-educate Physician #1. Further interview revealed that Physician #1 continued to perform procedures at the facility until he left in December 2018.	A 955		

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A 955	Continued From page 114 Interviews were attempted with Physician #1 and the Director of Surgical Services; however, both were unable to be reached and no longer worked for the facility.	A 955		
A1100	EMERGENCY SERVICES CFR(s): 482.55 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on observation, interview, record review, review of facility policies/procedures, and review of the American Heart Association/American Stroke Association Guidelines, it was determined the facility failed to meet the emergency needs of patients in accordance with acceptable standards of practice. The facility failed to ensure the Emergency Department was integrated with other departments of the facility to ensure the facility could immediately make available the full extent of its patient care resources to assess and render appropriate care for emergency patients, and failed to ensure the policies and procedures governing medical care provided in the Emergency Department were a continuing responsibility of the medical staff. Patient #12 presented to the Emergency Department (ED) on 12/04/18, in full cardiac arrest. On two different occasions, Patient #12 required multiple doses of Epinephrine (a medication to stimulate the heart) in an effort to sustain the patient's life. However, the facility failed to have enough medication to treat the patient, and medication had to be supplied to the	A1100	The facility failed to meet the emergency needs of patients with acceptable standards of practice. The CEO failed to provide oversight for the facility. The facility failed to integrate the ED with other departments of the facility. The facility failed to ensure policy procedures governing medical care in the ED where a responsibility of the medical staff. The facility failed to have a functioning governing board and did not convene per policy. The hospital staff and providers will be in-serviced on policy 700.709, MedSurg-Scope of Care, policy 700.315 ER Scope of Care, policy 200.401 Scope of Care (Facility). This will be verified by the in-service attendance log. MEC has requested the attendance of the ED Medical Director at their meetings. MEC reviewed and approved these policies, the ED Medical Director was present for the MEC meeting on 2/20/19. Peer review of two ED charts was requested by MEC of ED contract company and the results were presented and discussed in the 2/20/19 MEC meeting. The new Governing Board appointed a new CEO on 2/22/19 who will provide oversight to ensure quality care is being provided. This may be verified by board minutes. (CEO/Controller) The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly seated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes. (Controller)	2/22/2019 2/22/2019

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A1100	Continued From page 115 facility by the Emergency Medical Services (EMS) that had transported the patient to the ED. Observation of the facility's ED on 01/30/19 at 5:00 PM revealed four (4) ampules of Epinephrine were available for an adult patient and four (4) ampules of Epinephrine for a pediatric patient. However, all eight ampules of Epinephrine had expiration dates of 01/31/19, the next day, and the facility had no available Epinephrine to replace the medication and could not purchase any medication because their retail vendor stopped releasing medication to the facility due to unpaid debt. On 07/17/18, EMS was attempting to transfer a patient to the ED who was exhibiting signs and symptoms of an acute stroke. However, when EMS contacted the ED to inform them that they were en route with the patient, they were informed by RN #11 not to bring the patient to the ED because they would "kill this guy." Subsequently, EMS contacted a transport helicopter and the patient was flown to another facility. Further, the facility had an "Acute Stroke Practice Standard for the Emergency Department" in place with specific criteria and interventions for the medical staff to follow and implement when a patient presented to the Emergency Department (ED) with signs/symptoms of a stroke. However, the facility failed to implement the standard of care on 11/12/18 at 10:35 AM, when Patient #10 presented to the ED with a "significantly elevated blood pressure" and exhibiting signs and symptoms of a stroke. The facility failed to implement their Acute Stroke Practice Standard for the Emergency Department; subsequently, Patient #10 did not receive medical imaging	A1100	The facility failed to have a functioning telementry monitor located at the nursing station and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. The ED did not have functional pulse oximeters, or have functional biohazard "sharps container", limited casting supplies and out dated casting supplies. To correct this issue The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility staff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ae replaced now through weekly orders to our materaials supply vendor. The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facilty staff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ae replaced now through weekly orders to our materaials supply vendor.(CEO) The facility failed to ensure that the ED was integrated with other departments of the facility. The hospital staff and providers will be in-serviced on policy 700.709, MedSurg-Scope of Care, policy 700.315 ER Scope of Care, policy 200.401 Scope of Care (Facility). This will be verified by the in-service attendance log. MEC has requested the attendance of the ED Medical Director at their meetings. MEC reviewed and approved these policies on 2/20/19. Peer review of two ED charts was requested of ED contract company and the results were presented and discussed in the 2/20/19 MEC meeting . (CNO/Chief of Staff)	2/22/2019 2/22/2019

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A1100	Continued From page 116 including a non-contrast head computed tomography (CT) scan until after being admitted to the medical surgical floor and five (5) hours after arrival to the ED. In addition, the facility failed to administer Patient #10 the stroke scale assessment screening to determine the extent of deficits being experienced by the patient. On 11/12/18 at 4:20 PM, the results of a CT scan of the head for Patient #10 revealed the patient was experiencing an apparent evolving stroke. The patient was transferred to Facility #6 on 11/12/18 at 8:15 PM for treatment of an acute stroke. The facility failed to have more than one Tissue Plasminogen Activator (tPA) (a medication administered to dissolve blood clots, name brand Activase), used to treat patients who were having a stroke. Interviews revealed the facility had been unable to purchase the medication in the past because the medication cost $10,000. However, as of 01/24/19, the facility did not have a retail pharmacy vendor from which to purchase any medication. Tours of the Emergency Department (ED) on 01/23/19 and 01/30/19 revealed the facility did not have a functioning telemetry monitor (shows the electrical activity of the heart) located at the nursing station, and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. Further observations revealed eight (8) of nine (9) rooms in the ED did not have a functional pulse oximeter (a device used to measures the amount of oxygen in the blood). Observations in the ED also revealed none of the nine (9) ED rooms contained a functional biohazard "sharps" container. There were only two (2) biohazard "sharps" containers located in the ED; one	A1100	The facility failed to implement acute stroke standards therefore the stroke scale assessment screening was not performed on patient #10. The facility also failed to implement the standard of care in the ED on patient #10. Due to not adhering to the AHA Standards and NIH Stoke Protocol the facility requested that the ED contract company in-service their own physicians on the stroke protocol. Inservice logs and verification from in-service will be sent and placed in the employee files by 3/7/19. Air-Evac Educators re-educated the clinical staff in the ED on 2/25/19 on the acute stroke practice standards. The ED department will be in-service on policy 700.321 Stroke Policy. The ED Manager will monitor "Door to MD" and "Door to Thrombolytics" as part of QAPI process that meets weekly. This will be verified by the QAPI meeting minutes. (CNO) The facility was aware of previous employee statements which reflected poorly on the ED department and the facility. The ED staff were re-educated by the ED Manager on the Mission Statement, the employee job descriptions and the Policies and Procedures for the Emergency Department. This will be verified by the in-service attendance log. (ACNO/Human Resources Director) The facility failed to have a functioning telementry monitor located at the nursing station and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. The ED Central Cardiac Monitor has been repaired by DTG, initial payment submitted 2/11/2019 and final payment was submitted on 2/19/2019. Central monitor back in operation3/1/2019. Nursing staff has been making patients rounds every 5-10 minutes to visualize in room monitor on patients who require ongoing cardiac monitoring. If patient requires more frequent monitoring, 1:1 care is provided as ED is staffed with either 2 RNs or 1 RN and 1 Paramedic 24/7. (ACNO/CEO)	3/1/2019 3/1/2019 3/1/2019

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	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

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A1100	Continued From page 117 container was located in the hallway and another in the physician's charting room. Observations on 01/30/19 revealed ED staff had to transport used needles and devices through the hallway to get to a biohazard container to dispose of the items. In addition, observation of the casting room on 01/23/19 at 9:45 AM revealed it contained a limited number of supplies necessary to cast fractured bones of patients presenting to the ED in need of casting services. The ED's entire supply of casting tape was expired and the appropriate sizes were not available to treat various injuries.	A1100	The facility failed to have enough medication to treat a patient in the ED. The medication was available in five additional crash carts (25 syringes) located through-out the facility which were not accessed, and also in the inpatient pharmacy. Neither Administration nor the Pharmacy was notified that medication had been obtained from EMS, therefore their supply was not replenished. The facility also failed to have more than one Activase on hand. The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached. (CEO)	3/6/2019
A1103	INTEGRATION OF EMERGENCY SERVICES CFR(s): 482.55(a)(2) [If emergency services are provided at the hospital --] (2) The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the Emergency Department was integrated with other departments of the facility to ensure the facility could immediately make available the full extent of its patient care resources to assess and render appropriate care for emergency patients. Patient #12 presented to the Emergency Department (ED) on 12/04/18, in full cardiac arrest. On two different occasions, Patient #12 required multiple doses of Epinephrine (a medication to stimulate the heart) in an effort to sustain the patient's life. However, the facility	A1103	The facility failed to ensure that the ED was integrated with other departments of the facility. The hospital staff and providers will be in-serviced on policy 700.709, MedSurg-Scope of Care, policy 700.315 ER Scope of Care, policy 200.401 Scope of Care (Facility). This will be verified by the in-service attendance log. MEC has requested the attendance of the ED Medical Director at their meetings. MEC reviewed and approved these policies on 2/20/19. Peer review of two ED charts was requested of ED contract company and the results were presented and discussed in the 2/20/19 MEC meeting. (CNO/Chief of Staff)	3/6/2019

Signature: _____ Date: 3/4/19

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A1103	Continued From page 118 failed to have enough medication to treat the patient, and medication had to be supplied to the facility by the Emergency Medical Services (EMS) that had transported the patient to the ED. On 07/17/18, EMS was attempting to transfer a patient to the ED who was exhibiting signs and symptoms of an acute stroke. However, when EMS contacted the ED to inform them that they were en route with the patient, they were informed by RN #11 not to bring the patient to the ED because they would "kill this guy." Subsequently, EMS contacted a transport helicopter and the patient was flown to another facility. Interviews with staff revealed the facility failed to have medication available used to treat patients who were having a stroke. Tours of the Emergency Department (ED) on 01/23/19 and 01/30/19 revealed the facility did not have a functioning telemetry monitor (shows the electrical activity of the heart) located at the nursing station, and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. Further observations revealed eight (8) of nine (9) rooms in the ED did not have a functional pulse oximeter (a device used to measures the amount of oxygen in the blood). Observations in the ED also revealed none of the nine (9) ED rooms contained a functional biohazard "sharps" container. There were only two (2) biohazard "sharps" containers located in the ED, one container was located in the hallway and another in the physician's charting room. Observations on 01/30/19 revealed ED staff had to transport used needles and devices through the hallway to get to a biohazard container to dispose of the items. In addition, observation of the casting room on	A1103	The facility failed to have enough medication to treat a patient in the ED. The medication was available in five additional crash carts (25 syringes) located through-out the facility which were not accessed, and also in the inpatient pharmacy. Neither Administration nor the Pharmacy was notified that medication had been obtained from EMS, therefore their supply was not replenished. The facility also failed to have more than one Activase on hand. The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and another payment will be made to have Cardinal release orders. The medications which were identified as not being available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached. (CEO) The facility failed to have a functioning telementry monitor located at the nursing station and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. The ED did not have functional pulse oximeters, or have functional biohazard "sharps container", limited casting supplies and out dated casting supplies. To correct this issue the relationship with the material The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility staff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies are replaced now through weekly orders to our materials supply vendor. (CEO) The facility failed to have a functioning telemetry monitor located at the nursing station and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. The ED Central Cardiac Monitor has been repaired by DTG, initial payment submitted 2/11/2019 and final payment was submitted on 2/19/2019. Central monitor back in operation3/1/2019. Nursing staff has been making patients rounds every 5-10 minutes to visualize in room monitor on patients who require ongoing cardiac monitoring. If patient requires more frequent monitoring, 1:1 care is provided as ED is staffed with either 2 RNs or 1 RN and 1 Paramedic 24/7. (ACNO/CEO)	3/6/2019 2/22/2019 3/1/2019

Signature: _____ Date: 3/4/19

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A1103	Continued From page 119 01/23/19 at 9:45 AM revealed it contained a limited number of supplies necessary to cast fractured bones of patients presenting to the ED in need of casting services. The ED's entire supply of casting tape was expired and the appropriate sizes were not available to treat various injuries. The findings include: Review of the facility policy titled, "Procedure List for ED," revised January 2019, revealed the facility would provide services including treatment for cardiac and/or respiratory arrest; cardiac monitoring and treatment of arrhythmias; treatment of patients in respiratory distress; treatment for acute stroke, including the administration of thrombolytics (medications to dissolve blood clots); treatment of various fractures; treatment of trauma patients; hypertensive crisis; anaphylactic shock; disaster triage; treatment of acute myocardial infarctions (heart attack) including the administration of thrombolytics; and pediatric emergencies. Review of the facility's policy, "Radiology Scope of Service," approved February 2017, revealed the Radiology Department was a medical specialty that employed the use of an array of imaging technologies to diagnose or treat patient conditions. The policy stated that after normal business hours, a technologist would be "on call" and responsible for all services provided in the facility. The policy stated "after hours" the "on call" technologist was to be contacted by the hospital nursing staff for any and all emergencies that required their services. The policy also stated	A1103	The facility was aware of previous employee statements which reflected poorly on the ED department and the facility. The ED staff were re-educated by the ED Manager on the Mission Statement, the employee job descriptions and the Policies and Procedures for the Emergency Department. This will be verified by the in-service attendance log. **(ACNO/Human Resources Director)** The facility failed to have a functioning telementry monitor located at the nursing station and staff were unable to monitor a patient's cardiac status unless they were present in the patient's room. The ED Central Cardiac Monitor has been repaired by DTG, initial payment submitted 2/11/2019 and final payment was submitted on 2/19/2019. Central monitor back in operation3/1/2019. Nursing staff has been making patients rounds every 5-10 minutes to visualize in room monitor on patients who require ongoing cardiac monitoring. If patient requires more frequent monitoring, 1:1 care is provided as ED is staffed with either 2 RNs or 1 RN and 1 Paramedic 24/7. **(ACNO/CEO)** The Radiological Policy 300.441 Scope of Services was edited to change on call technologist response time to be within 15 minutes. The policy will be taken to QAPI to MEC and to the Governing Board for approval. The Radiology staff will be in-serviced on this policy changes. This will be verified by the QAPI meeting minutes. **(Director of Radiology)** EMS reported that during a code which began at 2002 and ended at 2155 a chest x-ray was not completed. The Radiology department was onsite during the times of the code and the x-ray was in fact ordered at 2119 completed at 2127. This can be verified by the eMAR time stamps. **(CEO)**	3/1/2019 3/1/2019 2/22/2019 3/1/2019

Signature: _____ Date: 2/4/19

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A1103	Continued From page 120 that the "on call" technologist would respond to the facility within forty-five (45) minutes of being contacted by facility staff. 1. Review of Patient #12's medical record revealed the patient arrived at the facility's ED on 12/04/18 at 8:02 PM. The record stated that report received from EMS, who had transported the patient to the facility, revealed the patient had attempted suicide, was unresponsive, and in full cardiac arrest (unconscious with no heart function or breathing) with cardio pulmonary resuscitation (CPR) in progress upon arrival. Patient #12 had also been intubated (a tube placed in the windpipe so oxygen could be delivered to the lungs) by EMS en route to the facility. Continued review of Patient #12's medical record revealed that upon arrival to the facility Patient #12 was assessed to have a weak carotid pulse and lifesaving measures continued. Patient #12 was administered twenty-two (22) ampules of Epinephrine from 8:08 PM until 8:55 PM, at which time it was determined that Patient #12 had a palpable pulse, and at 8:58 PM the patient was placed on a mechanical ventilator (a machine that assists a patient to breathe). Review of physician orders for Patient #12 dated 12/04/18 at 9:10 PM, revealed the ED physician ordered Patient #12 to have a chest x-ray obtained "STAT" (immediately). However, review of Patient #12's medical record revealed no evidence the chest x-ray was obtained as ordered. On 12/04/18 at 9:35 PM Patient #12 again went into cardiac arrest, and CPR was resumed, and eight (8) additional ampules of Epinephrine were administered to the patient between 9:35 PM and 9:55 PM, at which time Patient #12 was	A1103		

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A1103	Continued From page 121 pronounced deceased. Interview with RN #13 on 01/30/19 at 2:30 PM revealed she was working when Patient #12 was treated in the ED. The RN stated that she could not state emphatically why Patient #12 did not get the chest x-ray as ordered, but stated there was no one from the Radiology Department present in the facility while Patient #12 was receiving treatment. The RN also stated that the facility ran out of epinephrine in the ED while treating Patient #12. RN #13 stated supplies in the ED had been a problem for "some time." The RN stated that EMS had to provide epinephrine to the facility while Patient #12 was being treated, but was unable to say exactly how many ampules were "borrowed" from EMS. Interview with Paramedic #1 on 01/29/19 at 2:45 PM and with Emergency Medical Technician (EMT) #2 on 01/29/19 at 3.00 PM revealed they were the EMS personnel who transported Patient #12 to the ED on 12/04/18 and remained in the ED assisting facility personnel until Patient #12 was pronounced deceased. Paramedic #1 and EMT #2 stated that the ED staff never performed a chest x-ray on Patient #12. Continued interview with Paramedic #1 revealed that when they took Patient #12 into the ED, they also took their medication box into the facility. Paramedic #1 stated that they routinely take their medication box into this facility with them, because it is routine for the ED not to have the medication needed, and they often supply it to the facility. Further interview confirmed that the facility ran out of Epinephrine medication while treating Patient #12 and they used several ampules from their medication supply. Although Paramedic #1 and EMT #2 were unable to recall exactly how	A1103		

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A1103	Continued From page 122 many ampules of Epinephrine were supplied to the facility, they stated they had supplied "the majority" of Epinephrine administered to Patient #12. EMT #1 stated the facility's ED was the only one he had ever had to supply with medications or equipment during his entire career. Interview with the Director of Pharmacy on 01/29/19 at 11:00 AM revealed that as of 01/29/19, she was filling the facility's crash carts (carts utilized for the transportation and dispensing of emergency medication used in a lifesaving situation) with the last of the facility's "emergency medications" including Epinephrine, and she did not have the ability to obtain any more due to the facility's financial situation. Observation of the facility's ED on 01/30/19 at 5:00 PM revealed the ED had four (4) ampules of Epinephrine that could be administered to an adult patient and four (4) ampules of Epinephrine that could be administered to a pediatric patient. However, all eight ampules of Epinephrine had expiration dates of 01/31/19. 2. Review of an audio recording of an Emergency Medical Services (EMS) dispatch call recorded on 07/17/18, between the facility's ED and EMS Dispatch revealed the dispatch station called the ED on 07/17/18, exact time unknown, to communicate to the ED that EMS was en route to their facility with a patient who was believed to be having an acute stroke. RN #11 is heard answering the phone call and confirming that it was the ED. The dispatcher proceeds to tell the nurse that EMS was en route to the facility with a patient who appears to be having an acute stroke. The Nurse then states, "If this is a stroke symptom it needs to be flown, I mean we are just	A1103		

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A1103	Continued From page 123 going to kill this guy, you know what I'm saying. Just tell them it is critical that he gets treatment immediately." The dispatcher is then heard communicating with the EMS crew who was transporting the patient, and then stating to RN #11, "Okay, I'll call the helicopter." The nurse then replies, "thank you, dear," and the call ends. Interview with the EMS Director on 01/29/19 at 2:45 PM revealed he was the paramedic on the call when RN #11 instructed EMS not to bring the stroke patient to the ED. The EMS Director stated that at that time the ambulance transporting the patient was approximately sixteen (16) minutes from the facility. The Director went on to state that the helipad used for the helicopter to land and pick up the stroke patient was the helipad utilized by the facility and was located directly across the street from the facility. The Director stated that after EMS arrived at the helipad with the patient they waited another sixteen minutes for the helicopter to arrive to transport the patient. In addition, according to the EMS Director the flight from the facility's helipad to the receiving hospital located seventy-three (73) miles away was approximately thirty (30) minutes long. Further interview with the EMS Director revealed that EMS staff had since been informed by the facility nursing staff that the facility did not have any Tissue Plasminogen Activator (tPA) (a medication administered to dissolve blood clots); subsequently, the EMS Director stated any patient believed to be having an acute stroke would be transported to another acute care facility, despite the location or time of travel to the alternative facility. Interview with RN #11 on 01/29/19 at 6:45 PM	A1103		

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A1103	Continued From page 124 revealed that she was working in the ED when Dispatch called the facility informing them of the incoming stroke patient. RN #11 stated the ED physician working that night was the staff member who initiated the conversation with her to instruct EMS to "fly the patient out" instead of treating the patient in the ED. The RN stated the ED physician and she discussed the fact that the facility did not have radiology services in the facility from midnight until 7:00 AM, and a Computerized Tomography (CT) technician would have to be "called in," and then it would take an hour for the results to be available, and by that time, the patient "would be dead." Continued interview with RN #11 revealed working in the facility's ED was like working in a "low rent doctor's office." RN #11 stated that the most basic of laboratory studies were sent out to be processed and nursing staff had to search all over the building for medication, and then it may or may not be found. The RN stated the ED did not have even the "basic supplies." Interview with the Director of Pharmacy (DOP) on 01/23/19 at 2:45 PM revealed the facility had only one (1) dose of tPA medication available in the facility. The DOP stated that due to the cost of the medication she could not obtain any more. The DOP stated that the facility was in debt to the pharmacy supplier for approximately one-half million dollars, and they could not obtain any medications without paying "up front" for them. She further indicated tPA medication cost approximately ten thousand dollars and the facility did not have funds available to purchase the medication. 3. Tours of the Emergency Department (ED) on 01/23/19 at 9:45 AM and on 01/30/19 at 5:15 PM,	A1103		

Signature: _____ Date: 3/4/19

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A1103	Continued From page 125 revealed the facility had nine (9) ED rooms, two (2) of the rooms were dedicated for trauma services and one (1) of the rooms was dedicated for casting services. Continued observations on 01/30/19 at 5:15 PM revealed a telemetry monitor was located at the nursing station; however, the monitor was not operational and could not be utilized to monitor patients who had presented to the ED with suspected cardiac problems or patients who were experiencing an acute myocardial infarction (heart attack). Interviews on 01/30/19, at 5:20 PM with Registered Nurse (RN) #9, at 5:45 PM with RN #10, and at 2:30 PM with RN #13 revealed the telemetry monitor at the nursing station had not worked for "months." RN #13 stated there had been occasions when two or three patients were present in the ED who required cardiac monitoring; however, the only way tocontinuously monitor the patient's cardiac status was to stay in the room with the patient and observe the bedside monitor. All the staff interviewed stated it was impossible to stay in the room with each patient in the ED, and at times this had presented situations that placed the patients at risk for critical changes in their condition not being recognized timely and acted on immediately. Further review of the ED rooms revealed eight(8) of the nine (9) rooms did not have a working pulse oximeter. Further interviews on 01/30/19, at 5:20 PM with Registered Nurse (RN) #9, at 5:45 PM with RN #10, and at 2:30 PM with RN #13, revealed only one room in the ED was equipped to provide continuous pulse oximetry monitoring for a patient. The nurses stated that there were two	A1103		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A1103	Continued From page 126 (2) "portable stations" that they utilize for obtaining patient vital signs, which also contained disposable pulse oximetry equipment that was to be used on one patient and then discarded. However, the nurses stated that due to a lack of supplies in the ED and not having any additional disposable pulse oximeter sensors available, the staff utilized the same disposable senor for every patient in the ED. The staff were unable to say how long the sensors had not been available, but stated, "a while." Continued observations of the ED revealed none of the nine (9) ED rooms contained a functional biohazard "sharps" container. The only biohazard "sharps" containers located in the ED were in the hallway and in the physician's charting room. Observations on 01/30/19 revealed ED staff had to transport used needles and devices through the hallway to get to a biohazard container to dispose of the items, creating a substantial risk of exposure of a bloodborne illness or injury to patients, staff, and visitors in the ED. Continued interviews on 01/30/19, at 5:20 PM with Registered Nurse (RN) #9, at 5:45 PM with RN #10, and at 2:30 PM with RN #13 revealed the "sharps containers" in the rooms had not been functional for "a while." The staff stated they had to utilize the large sharps container in the hallway or the one in the physician's room. The staff interviewed stated they recognized this practice to be a "serious" problem related to infection control. 4. Observation of the casting room on 01/23/19 at 9:45 AM revealed it contained three (3) rolls of 1-inch casting tape each of which had an expiration date of October 2015; nine (9) rolls of	A1103		

Signature: _____ Date: 3/4/19

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	180021	A. BUILDING _____ B. WING _____	C 01/30/2019

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A1103	Continued From page 127 2-inch casting tape each of which had an expiration date of December 2018; one (1) roll of 2.5-inch casting tape with an expiration date of October 2015; and one 6-inch roll of casting tape with no expiration date present. Further review of the casting supplies revealed sixteen (16) casting sponges were present, one (1) with an expiration date of March 2017, seven (7) with an expiration date of June 2017, two (2) with an expiration date of October 2015, and six (6) with an expiration date of December 2015. Interview with the Casting Technician on 01/23/19 at 10:00 AM revealed he was aware that the casting supplies had expired but stated they were the only supplies available. The Casting Technician stated that the one (1) roll of 6-inch casting tape, which was used for large areas such as legs, is an item that is frequently used, because a fractured leg is a common injury seen in the ED. Continued interview with the casting technician revealed that due to the casting supplies "being so old" and out of date, it was difficult at times to make the castings stick orthey had to "make do" utilizing inappropriately sized tape to try and make a cast that would fit, because the appropriate size casting tape was not available. Interviews on 01/30/19 at 6:15 PM with the Chief Nursing Officer (CNO) and the Assistant Chief Nursing Officer (ACNO) revealed they denied having any knowledge of the facility having to "borrow" medications and supplies from EMS to operate the ED. However, continued interview with the CNO and ACNO revealed that the EMS Director had requested to meet with them "sometime in the summer" of 2018, because of concerns he had with the facility's ED. The CNO	A1103		

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A1103	Continued From page 128 and ACNO stated during the meeting they were informed by the Director of the phone call that had transpired between the ED and EMS Dispatch. The CNO and ACNO stated an investigation was initiated and they spoke with RN #11 and the physician who was working in the ED. According to the NCO and ANCO it was determined by RN #11 and the ED physician that due to the facility not providing neurological services, it would be better for the patient to be flown to another facility, and no changes were made in the ED as a result of the investigation. Continued interview with the CNO and ACNO revealed they were aware that the telemetry monitor was not working in the ED and they had made the Chief Executive Officer (CEO) and the Chief Financial Officer (CFO) aware; however, no action had been taken and the ED continued to not have a functioning cardiac monitor at the nurses' station. Continued interviews revealed the CNO and the ACNO were not aware of the lack of pulse oximetry sensors not being available in the ED. The CNO and ACNO also stated the facility had been out of biohazard sharps containers for the ED rooms for "months." The CNO and ACNO stated that decisions on which supplies were obtained were made on a day-to-day basis and they try to obtain the most critical supplies first, but due to the financial condition of the facility, not all needed supplies could be made available.	A1103		
A1104	EMERGENCY SERVICES POLICIES CFR(s): 482.55(a)(3) [If emergency services are provided at the hospital --] (3) The policies and procedures governing	A1104		

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A1104	Continued From page 129 medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff . This STANDARD is not met as evidenced by: Based on interview, record review, review of facility policies/procedures, and review of the American Heart Association/American Stroke Association Guidelines, it was determined the facility failed to ensure the policies and procedures governing medical care provided in the Emergency Department were established and evaluated on an ongoing basis. The facility had an "Acute Stroke Practice Standard for the Emergency Department" in place with specific criteria and interventions for the medical staff to follow and implement when a patient presented to the Emergency Department (ED) with signs/symptoms of a stroke. However, the facility failed to implement the standard of care on 11/12/18 at 10:35 AM, when Patient #10 presented to the ED with a "significantly elevated blood pressure" and exhibiting signs and symptoms of a stroke. The facility failed to implement their Acute Stroke Practice Standard for the Emergency Department; subsequently, Patient #10 did not receive medical imaging including a non-contrast head computed tomography (CT) scan until after being admitted to the medical surgical floor and five (5) hours after arrival to the ED. In addition, the facility failed to administer Patient #10 the stroke scale assessment screening to determine the extent of deficits being experienced by the patient. On 11/12/18 at 4:20 PM the results of a CT scan of the head for Patient #10 revealed the patient was experiencing an apparent evolving infarct in the right parietal area. The patient was transferred to Facility #6 on 11/12/18 at 8:15 PM for treatment	A1104	The facility failed to ensure that the ED was integrated with other departments of the facility. The hospital staff and providers will be in-serviced on policy 700.709, MedSurg-Scope of Care, policy 700.315 ER Scope of Care, policy 200.401 Scope of Care (Facility). This will be verified by the in-service attendance log. MEC has requested the attendance of the ED Medical Director at their meetings. MEC reviewed and approved these policies on 2/20/19. Peer review of two ED charts was requested of ED contract company and the results were presented and discussed in the 2/20/19 MEC meeting. (CNO/Chief of Staff) The facility failed to implement acute stroke standards therefore the stroke scale assessment screening was not performed on patient #10. Due to not adhearing to the AHA Standards and NIH Stoke Protocol the facility requested that the ED contract company inservice their own physicians on the stroke protocol. Inservice logs and verification from inservice will be sent and placed in the employee files by 3/7/19. Air-Evac Educators re-educated the clinical staff in the ED on 2/25/19 on the acute stroke practice standards. The ED department will be in-service on policy 700.321 Stroke Policy. The ED Manager will monitor "Door to MD" and "Door to Thrombolytics" as part of QAPI process that meets weekly. This will be verified by the QAPI meeting minutes. (CNO) Re-inservice the Radiology Department regarding the stroke policy 700.321 Stroke Protocol. The Radiology Department Manager keeps a daily log to monitor stroke protocols "Door to CT completed" and "Door to CT report" as part of the QAPI process that meets weekly. This will be verified by the QAPI meeting minutes. (Director of Radiology) The Radiological policy 300.421 Notification and Callback Procedure for On Call Radiological Technologist was edited to change on call technologist response time for a stroke protocol to be within 15 minutes. This policy will be taken to QAPI and to MEC and to the Governing Board for approval. The Radiology staff will be in-service on this policy changes. This will be verified by the QAPI meeting minutes and in-service log. (Director of Radiology)	2/22/2019 3/1/2019 3/1/2019 2/22/2019

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A1104	Continued From page 130 of an acute stroke. The findings include: Review of the facility's policy, Acute Stroke Practice Standard for the Emergency Department (ED), undated, revealed when a patient presented to the Emergency Department with a suspected acute stroke, the use of a stroke severity scale was recommended. In addition patients exhibiting signs and symptoms of a stroke should receive imaging including a non-contrast head computed tomography (CT) scan. The policy further stated that imaging should occur within twenty (20) minutes of arrival in the ED. The policy further stated that imaging should occur within twenty (20) minutes of arrival in the ED. Further review of the facility's Acute Stroke Practice Standard for the Emergency Department revealed a National Institute of Health (NIH) Stroke Scale was to be utilized when a patient presented with signs/symptoms of a stroke for the healthcare provider to objectively quantify any possible impairment caused by the stroke. Review of the American Heart Association/American Stroke Association Guidelines revealed time was critical when experiencing a CVA and immediate treatment could minimize the long-term effects of a stroke and/or even prevent death. The guidelines listed numbness and weakness especially affecting one side of the body, slurred speech, and confusion as classic warning signs of a stroke. In addition the guidelines classified a hypertensive crisis as a severe increase in blood pressure that could lead to a stroke. The guidelines also stated that a systolic (top number) of 180 millimeters of	A1104	The Radiological policy 300.441 Scope of Services was edited to change on call technologist response time to be within 15 minutes. The policy will be taken to QAPI to MEC and to the Governing Board for approval. The Radiology staff will be in-serviced on this policy changes. This will be verified by the QAPI meeting minutes and in-service log. (Director of Radiology)	2/22/2019

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A1104	Continued From page 131 mercury (mm Hg) or higher or a diastolic (bottom number) of 120 mm Hg or higher can damage blood vessels. Review of Patient #10's Emergency Department medical record revealed the patient presented to the ED on 11/12/18 at 10:35 AM, with severe hypertension (an increased blood pressure), left sided facial and arm heaviness and swelling of the left side of the tongue. In addition review of a History and Physical for Patient #10 dated 11/12/18, revealed Patient #10 also was exhibiting slurred speech and was characterized by familiar health care providers as not acting normally. The patient was also assessed to have a family history significant for stroke. Further review of the medical record revealed Patient #10 was administered Clonidine 0.2 mg (a medication to lower blood pressure) by mouth at 11:01 AM and the patient's blood pressure was recorded as 240/140 (normal 120/80) at 11:08 AM. The patient was triaged as "urgent." However, there was no evidence found to indicate the facility initiated their own Stroke protocol by conducted imaging of Resident #10 including a non-contrast head (CT) scan within twenty (20) minutes of arriving to the ED or administered the stroke scale assessment as required. Continued review of Patient #10's Emergency Department medical record revealed the patient's blood pressure was recorded as 252/146 at 11:27 AM and at 11:34 AM the patient was administered Metoprolol 5 mg (a medication to lower blood pressure) via Intravenous (IV) access. At 11:42 AM Patient #10's blood pressure was recorded as 238/142 and at 11:45 AM the patient was again administered Metoprolol 5 mg via Intravenous	A1104		

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A1104	Continued From page 132 (IV) access. At 12:20 PM the patient's blood pressure was recorded as 230/142 and the patient at that time was administered Hydralazine (a medication to lower blood pressure) 20 mg via IV. At 12:35 PM Patient #10's blood pressure was recorded as 183/120. At 2:22 PM the patient's blood pressure was recorded as 201/134 and at 2:56 PM the patient was administered Labetalol (a medication to lower blood pressure) 5 mg via IV. Further review of the patient's medical record revealed at 3:15 PM the decision was made to admit the patient to the medical surgical floor for management of hypertensive crisis, despite Patient #10 not receiving medical imaging including a non-contrast head (CT) scan within 20 minutes of arriving to the ED or being administered the stroke scale assessment as required by the facility's policies and procedures. Further review of Patient #10's medical record revealed the patient arrived at the medical surgical unit on 11/12/18 at 3:30 PM, and at 3:41 PM the patient's blood pressure was documented as 180/108. At 3:47 PM, the admitting physician documented that a CT scan of the head would be obtained "just to be on the safe side." Review of a Radiology Imaging Department Report for Patient #10 dated 11/12/18, revealed a CT of the head was obtained on the patient at 3:42 PM and the documented reason for the scan was "numbness of side head and tongue." Further review of the report revealed the findings of the head CT was "an apparent evolving infarct in right parietal area." Continued review of Patient #10's medical record revealed at 4:48 PM the results of Patient #10's	A1104		

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A1104	Continued From page 133 CT of the head was called to the admitting physician. Subsequently, at 6:15 PM, Patient #10 was transferred to Facility #6 for treatment of an acute stroke. Interview with RN #8 on 01/28/19 at 6:00 PM, reveled she was working in the ED on 11/12/18, when Patient #10 presented to the facility. RN #4 stated that the she was unaware why a CT scan of the head was not ordered for Patient #10 in the ED. The RN stated that the physician was aware that the patient's blood pressure was elevated. RN #4 stated she did not perform the NIH stroke scale assessment on Patient #10 because to the best of her recollection the patient was not exhibiting slurred speech or having any neurological deficits that she could recall, despite contrary documentation in Patient #10's medical record. Interview with Registered Nurse (RN) #4 on 01/29/19 at 12:45 PM revealed she provided care to Patient #10 after being admitted to the medical surgical floor. RN #4 stated she was familiar with the patient because he/she was employed at the facility. She stated the patient was "thick tongued" and the patient's speech was not normal. RN #4 stated the patient "wasn't acting right" and Patient #10's blood pressure continued to be elevated even after being administered "a large amount of medications." The RN stated after she evaluated Patient #10, she identified that a CT scan had not been performed in the ED which was routine protocol for the facility. RN #4 stated this was concerning "especially since we were familiar with (him/her) and something wasn't right." She stated she contacted the physician and orders were obtained for a CT scan. RN #4 stated the CT scan confirmed the patient was	A1104		

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A1104	Continued From page 134 having a stroke so an "immediate transfer" was arranged. Interview with Physician #5 on 01/29/19 at 4:30 PM revealed Patient #10 presented to the ED with swelling of the tongue, slurred speech, and high blood pressure. Physician #5 stated he felt that Patient #10 was "clinically stable" other than the patient's high blood pressure. Physician #5 stated when he examined Patient #10 the patient had already been admitted to the floor, after being "stabilized" in the ED. Physician #5 stated he was informed by nursing staff that the patient did not appear "normal," and a CT scan was ordered. Continued interview with Physician #5 revealed that as soon as the CT scan indicated Patient #10 was having a stroke, he immediately transferred Patient #10 to Facility #6. Interview with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed the NIH stroke scale assessment screening should have been administered to Patient #10 and a CT scan of the head obtained immediately upon the patient presenting to the ED. The COS also stated that Patient #10 should have never been admitted to the medical surgical floor in a hypertensive crisis due to the lack of staff to care for a critically ill patient, the facility not having adequate supplies, nor the capability to provide the level of care that Patient #10 required. Continued interview revealed the facility did not have a Cardiologist or Neurologist on staff to consult regarding these types of patients.	A1104		

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