

KAHCF

Kentucky Association of Health Care Facilities

IMPORTANT INFORMATION

Immediate Jeopardy Bulletin

This is the first edition of the reporting on Immediate Jeopardy (IJ) citations. KAHCF hopes by sharing the summaries of the (IJ) statement of deficiencies (SODs) our members will have an opportunity to evaluate their own practices and systems to avoid jeopardy citations. The KAHCF Immediate Jeopardy Task Force will continue to review all Immediate Jeopardy SODs to identify trends, patterns and make education recommendations. A 2014 annual report on the trends and patterns of the IJ surveys will be shared with members when the two remaining 2014 IJ SODs are made available. To date two IJ SODs from 2015 have been made available to KAHCF. An OIG report on the number of Immediate Jeopardy surveys in the first quarter of 2015 states there were nine (9) IJ surveys in nine (9) facilities. Below are summaries of the two available 2015 IJ survey SODs.

Summary 1- Recertification/Abbreviated Survey/ Partial Extended Survey- Tags: F157 (K) - Resident Rights/Notification of changes to designated individuals that affect resident well-being, F280 (K)- Resident Assessment/ Care plans must be reviewed and revised by qualified persons, F315 (J)- Quality of Care/ Resident's clinical condition demonstrates catheterization necessary, F323 (K)- Quality of Care/Accident Hazards.

The facility failed to have an effective system to determine the root cause of falls and implement interventions to prevent further falls. One resident had seven falls over a seven month period and the last two falls, occurring four days apart, resulted in head injuries. The last falls were determined to have occurred while the resident attempted to change clothing after incontinent episodes. The physician was notified 3.5 hours after the first of the last two falls but the physician nor family representative were notified until 8.5 hours after the final fall when the resident was found unresponsive. The resident was transferred to the Emergency Room and expired 20 hours after a large brain bleed was confirmed by an X-ray. A second resident had seven falls over a six month period, all related to incontinence, and sustained an injury to a shoulder, hit their head and received an abrasion and a skin tear. Notification to the physician for these three incidents did not occur timely. Reporting of the first incident to the physician did not occur for 7.5 hours after the incident and for the subsequent incidents notification did not occur until the next day. A third resident fell three times in one day and two months later sustained an injury after a fall. The physician was not notified for one hour after this fall. The fourth resident fell three times in six months and required stitches after the last fall. The facility policy did not reflect time frames to notify the physician or family representative after a resident fall or change in condition. The facility failed to have an effective system in place to ensure care plans were individualized based on resident assessments and failed to ensure care plans were revised with interventions to prevent additional falls. The facility failed to have an effective system to ensure toileting programs were implemented, monitored and revised to meet the incontinent needs of two of thirty two sampled residents. Documentation did not reflect the urinary frequency or continent episodes of one resident who had two falls while trying to change clothing and inconsistent documentation was noted on another resident who also sustained falls related to incontinence and attempts to self-toilet. The facility failed to have an effective system to ensure the resident environment was free of accident hazards and failed to determine the root cause analysis of resident

falls. The facility failed to monitor the implementation and effectiveness of processes to provide a safe environment. Also identified was a broken electrical plate and wheelchair arm pads that should be replaced to prevent skin tears. The Allegation of Compliance (AOC) was accepted and removal of jeopardy identified prior to the exit of the partial/extended survey.

Summary 2- Abbreviated/Partial Extended Survey- Tags: F 282 (J) Resident Assessment, F 323 (J) Quality of Care/ Accidents and Supervision

At 11:42 pm a resident exited his/her unit without an alarm sounding and exited through the unlocked doors to the front lobby without staff knowledge. At 12:30 am the resident attempted to re-enter the front lobby doors after recognizing it was too cold outside. However, these doors locked from the outside and re-entrance was prohibited. The resident walked around to the Ambulance Entrance and rang the doorbell. The staff answered the door to find the resident in street clothing of shoes, socks, blue jeans and a pull over shirt. The staff noticed the resident appeared cold upon entering the building with recorded weather temperatures of forty-two (42) degrees Fahrenheit at midnight with westerly wind at 8.1 miles per hour. The resident's alarm did not sound upon returning to the unit. Staff determined the battery was dead and alarm nonfunctioning. The facility provided a credible Allegation of Compliance but due to the re-education of staff, the date accepted was five days after the facility submitted date of compliance.