

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

Printed: 09/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2015
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NAME OF PROVIDER OR SUPPLIER ARMA HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 605 EAST MELVIN ST PO BOX 789 ARMA, KS 66712
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F 000	INITIAL COMMENTS	F 000		
F 499 SS=F	<p>The following citations represent the findings of complaint investigation #91706.</p> <p>483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS</p> <p>The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.</p> <p>Professional staff must be licensed, certified, or registered in accordance with applicable State laws.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 25 residents. Based on interview and record review, the facility failed to provide licensed professional staff to carry out the nursing care for the residents of the facility. Unqualified staff, with an RN (Registered Nurse) license that lapsed on 12/1/13, provided IV (intravenous) antibiotic treatment for 2 residents (#1 and #2) and administered and/or read TB (tuberculosis) tests for 8 staff in 2015.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the KSBN (Kansas State Board of Nursing) License Verification revealed Administrative Staff A ' s Registered Nurse License lapsed, effective 12/1/13. <p>The physician ' s order, dated 8/7/15, documented for resident #1 to start Invanz (an antibiotic)1000 milligrams IV every 24 hours, times 9 doses, first dose due by 8/8/15 at 1:00 PM.</p> <p>The nurse ' s note, dated 8/8/15 at 4:21 PM,</p>	F 499		

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

TITLE

(X6) DATE

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

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F 499	<p>Continued From page 1</p> <p>documented the resident received IV antibiotic via port (PICC - peripherally inserted central line, an intravenous access designed for long term use).</p> <p>The nurse ' s note, dated 8/9/15 at 3:21 PM, documented the resident continued on IV antibiotic.</p> <p>Review of the August 2015 MAR/TAR (medication administration record/treatment administration record) revealed the record lacked documentation of the antibiotic administration ordered to begin 8/8/15.</p> <p>On 9/24/15 at 12:05 PM, Administrative Staff A stated when corporate investigated this last week, staff were not able to find the TAR for this resident ' s IV antibiotic that began 8/8/15. Staff A stated everything was in the record except that one page. Staff A felt an employee took it.</p> <p>On 9/24/15 at 12:59 PM, Direct Care Staff D reported Administrative Staff A told Staff D to lay the resident down one day so he/she could do the resident ' s IV. That was in August 2015. There was not another RN on duty, at that time, there was an LPN and he/she was not able to do IV treatments, so Staff A did it. Staff D had not told anyone about this because Staff A was the administrator, and Staff D felt if he/she told Staff A no, he/she would get fired.</p> <p>On 9/24/15 at 1:06 PM, Licensed Nursing Staff E reported he/she is an IV certified Licensed Practical Nurse. Around the first week of August, the resident had an IV antibiotic due to be administered, there was no RN working but Administrative Staff A that day and it was during the week. Staff A told Staff E he/she was going to go start the IV on the resident, went in the</p>	F 499			

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F 499	<p>Continued From page 2</p> <p>resident ' s room, shut the door, then when Staff A came out of the resident ' s room, the IV was started through the port. Then, when Staff E heard the IV pump beeping, indicating the IV infusion was finished, Staff A again went in the resident ' s room, shut the door, then came out and the IV infusion was stopped. Staff E did not know Staff A did not have a current RN license at the time. When the corporate nurse was here and Staff E gave him/her this information, Staff E was told if he/she did not physically see Staff A access the port, it did not happen. When Staff E found out Staff A did not have a current nursing license, Staff E did not question Staff A about those incidents.</p> <p>On 9/24/15 at 1:38 PM, Direct Care Staff F reported in August 2015, both staff RN ' s were on vacation and Administrative Staff A came to Staff F and Staff D and asked them to lay down the resident so he/she could do the IV. Staff F watched Staff A set up the IV in the medication room and put the antibiotic mix into the IV bag. Then Staff A went into the resident ' s room. Staff F walked in to the resident ' s room while Staff A was putting the needle into the port, around 1:00 or 1:30 PM, near shift change and it was the last thing Staff F remembered doing that shift. Staff F was told Staff A was an RN and never thought anything else about it. But recently, another staff member told Staff F that Staff A had a lapsed license.</p> <p>On 9/24/15 at 3:50 PM, Direct Care Staff G reported he/she recalled at least 2 different days the week of 8/8/15 when the resident was on an IV antibiotic through the port when Administrative Staff A administered the medications in the port. Staff G watched Staff A take the needle out of the port and stop the antibiotic. Staff G had to go get</p>	F 499			

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F 499	<p>Continued From page 3</p> <p>Staff A when the IV pump was beeping because Staff A was the only registered nurse in the facility. Staff K was in the facility, but is an LPN and cannot do port IV ' s. Normally, Licensed Staff C would do the IV antibiotics, but that week was on vacation and so was the other RN.</p> <p>On 9/25/15 at 9:39 AM, Direct Care Staff I reported sometime in the beginning weeks of August, Staff I was laying the resident down in bed, and the resident said that Administrative Staff A was on his/her way in to the facility to start the resident ' s IV antibiotics through the port because the nurse who was working was not skilled to perform the port access and Staff A had to do it. Staff I remembered that because he/she thought it was nice that Staff A would come in on his/her weekend off to do that. Staff I did see Staff A arrive a few minutes later, went into the medication room and set up the IV supplies, and then took them into the resident ' s room and started the IV through the port on the resident ' s chest.</p> <p>On 9/25/15 at 9:57 AM, Direct Care Staff J stated that at the beginning of August 2015, Administrative Staff A came in on a weekend to start an IV through the resident ' s port because the nurse was an LPN and cannot do anything with the port. Also, on another day that week, Staff A told Staff J to lie the resident down after lunch, so Staff A could do something with the resident ' s port that the resident needed to be laying down for. Staff J laid the resident down and Staff A went in the resident ' s room to do something with the port.</p> <p>On 9/25/15 at 10:26 AM, Licensed Nursing Staff K reported he/she was an IV certified LPN (Licensed Practical Nurse), but cannot touch a</p>	F 499			

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F 499	<p>Continued From page 4</p> <p>central line port due to nursing standard of practice. Staff K stated that Staff A accessed the resident ' s port and administered the IV antibiotic on 8/8/15 and 8/9/15 and also on another week day a few days later, but was not able to recall that date. Staff K stated he/she still had the text message on his/her cell phone from Staff A asking what time he/she needed to come to the facility to start the IV. This text was observed on staff K ' s cell phone and documented, on 8/8/15 at 9:05 AM, Staff A asking Staff K what time the IV needed to be started, he/she had been told before 1:00 PM. Staff K responded with a reminder of the IV at 12:52 PM, to which staff A responded he/she was about a block away. On 8/9/15 at 12:02 PM, Staff A texted Staff K that he/she would be there in a few minutes to start that antibiotic. Staff K stated he/she observed Staff A access the resident ' s port on 8/8/15 and administer the IV antibiotic.</p> <p>On 9/25/15 at 12:24 PM, Administrative Staff A reported his/her license for nursing was not current; it had been lapsed since 12/1/13. When the phone number from the previous mentioned text message about starting the antibiotic was read to Staff A, he/she confirmed the phone number was his/her personal cell phone number.</p> <p>On 9/25/15 at 11:57 AM, Licensed Staff C reported he/she was off on the weekend of 8/8/15. Staff C did access the resident ' s port for the IV antibiotic later in the week, on a weekday.</p> <p>The physician order, dated 6/13/15, documented resident #2 to start Meropenem Solution (an antibiotic) reconstituted 500 mg (milligrams), use 500 mg IV (intravenously) three times daily for UTI (urinary tract infection) for 5 days.</p>	F 499			

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F 499	<p>Continued From page 5</p> <p>The nurse ' s note, dated 6/13/15 at 1:37 PM, documented the resident ' s IV was initiated after 2 attempts in the right forearm, and IV antibiotic therapy started at 12:00.</p> <p>On 9/24/15 at 1:06 PM, Licensed Nursing Staff E reported on a Saturday in June, 2015, Staff E was working and could not get an IV started and called Staff A to help, who said he/she could come in and try to start it. Staff A arrived to the facility and went into the resident ' s room with Direct Care Staff F, where the supplies to start the IV remained set up from Staff E ' s failed attempts to start the IV. Then, when staff A came out of the room, the IV was in.</p> <p>On 9/24/15 at 1:38 PM, Direct Care Staff F reported he/she witnessed Administrative Staff A start an IV on resident #2, using a butterfly needle and hooked up the IV with an antibiotic mixed in. It occurred, at the first of the summer, in June, 2015. Staff F stated the other nurse had trouble starting the IV and staff F specifically asked Staff A if he/she could watch Staff A start the IV, and was told by Staff A it was fine to watch.</p> <p>On 9/25/15 at 12:24 PM, Administrative Staff A reported his/her license for nursing was not current; it had been lapsed since 12/1/13.</p> <p>Furthermore, staff interviewed reported Staff A had administered their TB (tuberculosis) skin tests early in 2015. On 9/25/15 at 11:46 AM, Staff A produced several employee TB sheets and stated there were several that he/she signed as observed the result of the TB skin test and signed them as by Staff A, RN (registered nurse). Seven of the TB skin tests documented Staff A had read the results of the test. Staff A stated he/she had not administered any TB skin tests to any staff. A</p>	F 499			

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F 499	<p>Continued From page 6</p> <p>copy of a TB test sheet was later produced by a staff member, which documented the test was administered by Staff A, on 2/25/15 and results read by Staff A on 2/27/15. On all of the mentioned TB skin test documents, Staff A signed as a registered nurse.</p> <p>The facility failed to provide qualified licensed nursing staff to administer IV antibiotics through a PICC line for resident #1 in August 2015, to start an IV and administer antibiotics for resident #2 in June 2015 and to administer and read the results of TB skin tests for 8 facility staff in February 2015, all performed by a staff member whose registered nurse license lapsed on 12/1/13. The deficient practice of an unlicensed person completing licensed nurse duties has the potential to affect all residents.</p>	F 499			