

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

PRINTED: 12/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/19/2015
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NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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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
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance 12/19/15, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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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 000	INITIAL COMMENTS A Recertification Survey was conducted on 11/17/15 through 11/19/15 with deficiencies cited at the highest Scope and Severity of a "D". F 158 SS=C 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services.	F 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Margaret B. Curtis</i>	TITLE <i>Administrator</i>	(X6) DATE 12-10-15
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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 156	<p>Continued From page 1</p> <p>Including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility</p>	F 156	<p><u>F 156 (SS=C) 483.10(b) (5) – (10), 483.10(b) (1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</u></p> <p><i>Corrective Action for Residents Found to Have Been Affected:</i> On 11/25/2015, the Clinical Compliance Coordinator was counseled on following the facility policies related to Notices of Medicare Non-Coverage, and, in particular, the need to have signed and dated notices in the resident's record. On 12/8/2015, the Clinical Compliance Coordinator mailed the Advance Beneficiary Notices (ABN) to the legal representatives for Resident #2 and Unsampld Resident A and Unsampld Resident B, again, by Certified Mail; documentation was placed in the respective medical record for each resident. On 12/9/2015, the Clinical Compliance Coordinator telephoned the legal representatives for Resident #2 and Unsampld Resident A and Unsampld Resident B to advise them of the Medicare Non-</p>	

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F 156	<p>Continued From page 2</p> <p>written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and review of Notice of Medicare Non-Coverage letters and of the facility's Notice of Medicare Non-Coverage policy, it was determined the facility failed to notify three (3) of three (3) residents selected who received Advanced Beneficiary Notice of Non-Coverage (Resident #2 and Unsampled Resident A and B,) prior to the date that Medicare benefits would terminate.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Advance Beneficiary Notice of Non-Coverage (ABN), dated August 2014, revealed when the ABN was not delivered in person, the contact was to have been documented in the record. The facility was to have followed telephone contacts immediately by either a hand-delivered, mailed, e-mailed, or faxed ABN. The beneficiary or the beneficiary's representative must sign and retain the ABN and send a copy of the signed ABN to the facility for retention in the beneficiary's record. Keep a copy of the unsigned ABN on file while awaiting receipt of the signed ABN. If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to obtain a signature in</p>	F 156	<p>Coverage and the importance of signing and dating the ABN; this telephone call was witnessed by the Director of Nursing and documentation was placed in the respective medical record for each resident.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i> <i>Identification of Other Residents Having the Potential to be Affected</i> On 12/9/2015 all current residents who receive Medicare benefits and who were eligible for Notices of Medicare Non-Coverage were reviewed to validate that signed and dated notices were in the resident's file and that documentation was placed in the medical record of each resident.</p> <p><i>Measures or Systemic Changes Made to Avoid Reoccurrence</i> The Medicare Committee will audit (weekly) the residents who receive Medicare benefits and who are eligible for Notices of Medicare Non-Coverage. These reviews will include validating</p>	

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F 156	<p>Continued From page 3</p> <p>the appropriate records or the ABN. The notice instructed the resident of their appeal rights.</p> <ol style="list-style-type: none"> 1. Review of Resident #2's Notice of Medicare Non-Coverage letter, during the Demand Bill Review, revealed the resident's current therapy services would end on 11/19/15; however, the letter was not signed or dated. 2. Review of Unsampled Resident A's Notice of Medicare Non-Coverage letter, during the Demand Bill Review, revealed the resident's current therapy services would end on 11/10/15; additionally, the letter was not signed or dated. 3. Review of Unsampled Resident B's Notice of Medicare Non-Coverage letter, revealed the resident's current therapy services would end on 11/05/15 and this letter was not signed or dated. <p>Interview with the Clinical Coordinator (CC) for Compliance, on 11/19/15 at 2:05 PM, revealed she was responsible for issuing the Notices of Medicare Non-Coverage and stated she mailed these to the residents' guardians or Power of Attorney (POA) but "hardly ever got a response back." There was no date or time noted as to when the notice was sent, or if the guardian or POA ever received the letter to verify whether or not they wanted to appeal. The CC stated she was told she had seven (7) days from the time she received the notice from therapy to mail them out and the notices were not sent as a certified letter. She also stated Unsampled Resident B's POA did come to the facility to visit frequently but the CC had been unable to meet with the POA, in order to obtain the signature and explain the right to appeal this decision.</p>	F 156	<p>eligibility of non-coverage, education of the beneficiary, and receipt of signed and dated notices.</p> <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The Medicare Committee will submit the results of the weekly reviews of the Notices of Medicare Non-Coverage to the Administrator each week for review and follow-up.</p> <div style="border: 1px solid black; width: 100px; height: 30px; margin: 20px auto; text-align: center;">12-19-2015</div>	12-19-2015	

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F 158	Continued From page 4 Interview with the Administrator and Director of Nursing (DON) on 11/19/15 at 3:45 PM, revealed they were unaware the forms had not been signed prior to the services ending and stated the notices would be sent by certified mail in the future.	F 158	<u>F 281 (SS=D) 483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u> <i>Corrective Action for Residents Found to Have Been Affected:</i> On 11/20/2015, the LPN cited in F 281 was suspended and will not return to work as an LPN until the facility has received a copy of the active license. <i>Identification of Other Residents Having the Potential to be Affected</i> On 11/20/2015, the Director of Nursing validated that all licensed or registered nurses on staff have an active license and that these nurses are in good standing with the Kentucky Board of Nursing. On 12/1/2015, the Human Resources Director will validate that all newly hired licensed and registered nurses have professional licenses validated before hire. <i>Measures or Systemic Changes Made to Avoid Reoccurrence</i> On 11/19/2015, the Licensed Nurse Renewal Policy was revised		
F 281 SS=D	483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, Personnel record review, and review of Online Validation results and Kentucky Board of Nursing (KBN) licensure requirements, it was determined the facility failed to ensure all licensed staff had completed the annual renewal of their nursing licenses by the renewal completion date of 10/31/15. During the Personnel Record Review of four (4) staff members, it was noted one (1) of (2) two licensed staff had failed to renew their license, prior to 10/31/15, as required by the Kentucky Board of Nursing (KBN.) The findings include: Interview with the Director of Nursing (DON), on 11/19/15 at 1:50 PM, revealed their was no policy for renewal of the licenses. However, a review of the KBN licensure requirements, from the KBN website revealed, "Reinstatement for Failure to Renew: If you failed to renew between September 15 and October 31 of the current year, you must meet all of the reinstatement requirements. There	F 281			

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F 281	<p>Continued From page 5</p> <p>is no grace period for renewal of a Kentucky nursing license. If you were exempt from meeting the continuing competency, you must earn the CE before your license will be reinstated.</p> <p>Review of the Personnel Records on 11/19/15, revealed Licensed Practical Nurse (LPN) #1 was hired on 08/24/15 and the file stated the current LPN license was to expire 10/31/15.</p> <p>Review of the Online Validation Results for LPN #1 on 11/19/15, revealed the LPN's license had lapsed.</p> <p>Further interview with the DON, on 11/19/15 at 1:50 PM, revealed the DON had been reminding staff members to renew "since the first of August." The DON had completed an audit on 10/29/15 and there were two (2) licensed staff that had not renewed and they were reminded again. The DON stated the corporation pays for the renewals, all staff were aware this needed to have been completed and they were to have ran a copy of the Online Validation Results and turned them to the Personnel Office, on completion of the renewal. The DON spoke with the LPN, who stated she had a copy of the receipt for the fees paid but no validation result to ensure this was completed. The LPN was suspended until she could be re-instated.</p>	F 281	<p>by the Administrator and Director of Nursing. Staff receiving notification from respective licensure governing body of the need to renew license/certification will renew in a timely manner. The Facility Human Resources Department will verify licenses of ALL Licensed Nursing Staff upon hire and check for renewal on or about October 15th of the CURRENT year looking at the date of expiration. The date of expiration if license have been renewed, will be dated for the FOLLOWING year. The expiration date of all Kentucky licensed nurses occurs on October 31st of each year. The Human Resources Department will contact any licensed staff member identified to remind them of the license renewal requirement. The Corporate Staff Trainer will review all license renewals on or about October 22nd. Corporate</p>	
F 282 SS=D	<p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	F 282		

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Dawson Pointe

Provider # 185263

Survey Completed: 11-19-2015

Staff Trainer will inform any licensed staff member identified as not having renewed that they will only be scheduled until October 31st of current year until they provide proof of validation for the following year. The Corporate Trainer will notify the Human Resources Department of any licensed staff member that has not completed renewal on or about October 22nd of current year. Human Resources, upon receiving the list of non-renewals from the Corporate Staff Trainer, will provide the list of those licensed staff members identified as not yet being renewed to the Director of Nursing. The Director of Nursing will ONLY schedule the licensed staff member(s) listed as not yet being renewed until October 31st of the current year UNTIL validation of license for the following year is provided.

***Plans to Monitor Performance
for Sustained Solutions***

The Corporate Staff Trainer will

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Dawson Pointe

Provider # 185263

Survey Completed: 11-19-2015

submit the status of each licensed nurse to the Administrator at the end of October each year for review, action and follow-up.

12-19-2015

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F 282	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to provide care in accordance with the resident's written plan of care for one (1) of fifteen (15) sampled residents (Resident #2). Resident #2 had been receiving Haldol 20 milligrams (mg) since admission in 2012 and was care planned to attempt a gradual dose reduction (GDR) as indicated or ordered; however, there was no documented evidence a GDR was attempted or of the physician's rationale not to reduce the medication.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Comprehensive Care Plan", not dated, revealed the care plan documents how each residents' daily care needs are provided by the nursing staff. The development, implementation and maintenance of a resident's care plan as initiated by the admitting licensed nurse, is a interdisciplinary process.</p> <p>1. Record review revealed the facility admitted Resident #2 on 07/30/12 with diagnoses which included Schizophrenia, Bipolar Disorder, and Dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/15/15, revealed the facility assessed Resident #2's cognition as intact with a Brief Interview of Mental Status score of fifteen (15), which indicated the resident was interviewable.</p> <p>Review of Physician's Orders revealed the resident had been receiving Haldol 20 mg every</p>	F 282	<p><u>F 282 (SS=DI) 483.20(K)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</u></p> <p><i>Corrective Action for Residents Found to Have Been Affected:</i> On 11/18/2015, the Pharmacist discussed with the Physician and Psychiatrist the need for a Gradual Dose Reduction (GDR) for Resident #2. The Physician and Psychiatrist have stipulated that a GDR is contraindicated for Resident #2. On 11/18/2015, the Comprehensive Care Plan was updated for Resident #2 who is receiving Haldol (20mg). Resident #2 is receiving care according to the Comprehensive Care Plan for Resident # 2.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i> On 11/25/2015 the Medication Regimen Reviews and Pharmacy Consultant Records were examined to assure that the GDR was addressed by the Consulting Pharmacist for each resident. On 11/25/2015, the Behavior Committee whose members include the Director of Nursing, Assistant Director of Nursing,</p>		

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F 282	<p>Continued From page 7 day since admission.</p> <p>Review of Resident #2's Comprehensive Care Plan, dated 08/22/12, revealed the resident was at risk for significant side-effects from the Haldol, to include Extrapyramidal Reaction (EPS,) and drug induced movement disorders that include acute and tardive symptoms. Further review revealed an intervention to conduct a GDR, as indicated and ordered.</p> <p>Review of the Chronological Records of Medication Regimen Reviews and Pharmacy Consultant Records, dated 08/21/12 through 11/13/15, revealed no mention of a GDR for Resident #2, except for a notation on 04/15/13 that the resident's current regimen seems to be helping per the last psychologist's reports as "best she's been one year," and three (3) mentions of the psychiatrist's visits with no changes in medications noted. Review of the Psychiatrist's Progress Notes and the routine monthly Physician Orders for September through November 2015 revealed no mention of a reduction of the Haldol or the physician's refusals to decrease the medication, due to the resident's instability. There was no documented evidence a GDR was attempted or documentation from the physician that a GDR was clinically contraindicated.</p> <p>Interview (Post Survey) with the Minimum Data Set (MDS) Coordinator, on 11/30/15 at 12:10 PM, revealed the requirement for the GDR was an intervention for all residents who are receiving antipsychotic medications and this should have been followed.</p> <p>Interview (Post Survey) with the Director of</p>	F 282	<p>Consulting Pharmacist, Psychiatrist, and Social Service Director reviewed all residents who receive antipsychotic medications to assure that a GDR had been addressed for each resident and that the related information was documented in the medical record for each resident and the Comprehensive Care Plan was updated. Each resident is receiving care according to the Comprehensive Care Plan.</p> <p><i>Measures or Systemic Changes Made to Avoid Reoccurrence</i> On 11/25/2015 and in all future meetings of the monthly Behavior Committee, the Behavior Committee will review the Medication Regimen Reviews and Pharmacy Consultant Records to assure that each resident who receives antipsychotic medications has been reviewed for a GDR by the Consulting Pharmacist. The Comprehensive Care Plan will be reviewed for each resident receiving antipsychotic medications to assure that the Comprehensive Care Plan is being followed.</p>	

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F 282	Continued From page 8 Nursing (DON), on 11/30/15 at 12:00 PM, revealed the requirement of the GDR was an intervention on the psychotropic medications and the care plan was to have been followed by staff attempts to ensure that all medications are reviewed every six (6) to twelve (12) months. The DON stated this resident was difficult to stabilize on the psychotropic medication and the physician "felt strongly about not reducing the medication" but the physician did not document this in the chart.	F 282	<p><i>Plans to Monitor Performance for Sustained Solutions</i> The reviews of the Medication Regimen Reviews and Pharmacy Consultant Records and the Comprehensive Care Plan reviews that are completed by the Behavior Committee will be submitted to the Quality Assurance (QA) Committee for review, recommendations and follow-up. The QA Committee meets monthly and includes the Medical Director, Administrator, Director of Nursing, Quality Assurance Nurse, Clinical Coordinator and Social Service Director.</p> <div style="border: 1px solid black; width: 100px; height: 40px; margin: 10px auto; text-align: center;">12-19-2015</div> <p><u>F 329 (SS=D) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</u></p> <p><i>Corrective Action for Residents Found to Have Been Affected: The need for a Gradual Dose</i></p>	12-19-2015	
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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F 329	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy and procedure review, it was determined the facility failed to ensure an antipsychotic gradual dose reduction (GDR) was completed per the facility care plan or the physician documented the clinical rationale for not conducting a GDR, for one (1) of fifteen (15) sampled residents (Resident #2). Resident #2 had been on Haldol 20 milligrams (mg) every day since admission in 2012, with no evidence of an attempted GDR or rationale as to why not completed.</p> <p>The findings include:</p> <p>Review of facility policy titled, "Antipsychotic Reduction Plan," dated 11/17/15, revealed "The review for GDR begins upon admission, by the attending physician in collaboration with the consultant pharmacist and the facility psychiatrist. All residents utilizing antipsychotics are reviewed periodically by the Pharmacy/ Therapeutics/ Behavior Committee, led by the consultant pharmacist. All residents who receive antipsychotic drugs receive a GDR, unless clinically contraindicated. In an effort to lower the dose or discontinue the drugs."</p> <p>Record review revealed the facility admitted Resident #2 on 07/30/12 with diagnoses which included Schizophrenia, Dementia with Behavioral Disturbance and Bipolar Disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/15/15, revealed the facility assessed Resident #2's cognition as Intact with a</p>	F 329	<p>Reduction was completed on 11/18/2015. On 11/18/2015, a physician order was received to not attempt a Gradual Dose Reduction for Resident #2 who is receiving Haldol (20mg) and the order includes the clinical rationale for not conducting the GDR for this resident. The Comprehensive Care plan was updated for Resident #2 on 11/18/2015.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i></p> <p>On 11/25/2015, the Behavior Committee whose members include the Director of Nursing, Assistant Director of Nursing, Consulting Pharmacist, Psychiatrist, and Social Service Director reviewed all residents who receive antipsychotic medications to assure that a GDR has been addressed for each resident and that the related information was documented in the medical record for each resident and the Comprehensive Care Plan was updated.</p>	
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F 329	<p>Continued From page 10</p> <p>Brief interview of Mental Status score of fifteen (15), which indicated the resident was interviewable.</p> <p>Observations and interview with Resident #2, on 11/18/15 at 2:00 PM and 11/19/15 at 8:40 AM, revealed the resident was calm, quiet, alert and oriented to person, place and time, had been at the facility "six and one half years," and had no concerns and no visible behaviors or distress.</p> <p>Review of Physician's Orders revealed the resident had been receiving Haldol 20 mg every day since admission.</p> <p>Review of the Chronological Records of Medication Regimen Reviews and Pharmacy Consultant Records, dated 08/21/12 through 11/13/15, revealed no mention of a GDR for Resident #2, except for a notation on 04/15/13 that the resident's current regimen seems to be helping per the last psychologist's reports as "best she's been one year," and three (3) mentions of the psychiatrist's visits with no changes in medications noted. There was no documented evidence a GDR was attempted or documentation from the physician that a GDR was clinically contraindicated.</p> <p>Review of the Psychiatrist's Progress Notes and the routine monthly Physician Orders for September through November 2015 revealed no mention of a reduction of the Haldol or the physician's refusals to decrease the medication, due to the resident's instability.</p> <p>Interview with the Director of Nursing (DON), on 11/18/15 at 3:30 PM, revealed she had just been assigned to follow up on the GDRs and stated the</p>	F 329	<p>Measures or Systemic Changes Made to Avoid Reoccurrence</p> <p>On 11/25/2015 and in all future meetings of the monthly Behavior Committee, the Behavior Committee will review each resident receiving antipsychotic medications for the need of a GDR. The medical record and Comprehensive Care Plan will be addressed accordingly.</p> <p>Plans to Monitor Performance for Sustained Solutions</p> <p>The monthly GDR reviews of residents receiving antipsychotic medications that are completed by the Behavior Committee will be submitted to the Quality Assurance (QA) Committee for review, recommendations and follow-up. The QA Committee meets monthly and includes the Medical Director, Administrator, Director of Nursing, Quality Assurance Nurse, Clinical Coordinator and Social Service Director.</p>	12-19-2015	12-19-2015

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NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
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F 329	Continued From page 11 Psychiatrists were extremely good about making recommendations and adjusting the medications, as needed. The DON reviewed previous documentation from the Psychiatrist, to determine if a GDR had been recommended and the only record found was for 10/31/14, which stated the Haldol was to have been reduced to 20 mgs at bedtime. However, the resident had been on that dose since admission (07/30/12) and the DON was unsure if the order had ever been questioned.	F 329	<u>F 428 (SS=D) 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</u>		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the Consultant Pharmacist reported drug irregularities to the attending physician and the Director of Nursing (DON) related to Gradual Dose Reduction (GDR) recommendations for one (1) of fifteen (15) sampled residents (Residents #2). Resident #2 had been receiving Haldol 20 milligrams (mg) since admission; however, there was no evidence the pharmacist had identified	F 428	<i>Corrective Action for Residents Found to Have Been Affected:</i> On 11/18/2015, the Pharmacist discussed with the Physician and the need for a Gradual Dose Reduction (GDR) for Resident #2 who was receiving Haldol (20mg). On 11/18/2015 the Pharmacist discussed with the Psychiatrist the need for a Gradual Dose Reduction (GDR) for Resident #2. Documentation is made in the medical record and the Comprehensive Care Plan. <i>Identification of Other Residents Having the Potential to be Affected</i> On 12/10/2015 the Consulting Pharmacist has identified the need for a GDR on each resident who receives antipsychotic medications. On 11/18/2015, the Behavior Committee whose members include the Director of Nursing, Assistant Director of Nursing, Consulting Pharmacist, Psychiatrist, and Social Service		

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F 428	<p>Continued From page 12 the need to recommend a dose reduction.</p> <p>The findings include:</p> <p>Review of the facility's "Consultant Pharmacists Services Provider Requirements," undated, revealed the consultant pharmacist provides or supervises services, including, but not limited to: Reviewing the medication regimen of each resident at least monthly, utilizing State and/or Federal guidelines and documenting and reviewing the findings; Submitting a written report and recommendations each review; Communicating to the responsible physician potential, or actual problems, detected relating to medication therapy orders; and Submission of a written report and recommendations, resulting from the review, to the physician and/or the DON.</p> <p>Record review revealed Resident #2 was admitted on 07/30/12 with diagnoses to include Bipolar Disorder, Dementia with Behavioral Disturbance and Schizophrenia. Review of Physician Orders, revealed Resident #2 had been receiving Haldol 20 milligrams (mg) since admission, on 07/30/12.</p> <p>Review of the Medication Regimen Reviews and Pharmacy Consultant Records for Resident #2, dated 08/21/12 through 11/13/15, revealed no mention of a GDR.</p> <p>Interview with the Director of Nursing (DON), on 11/18/15 at 3:30 PM, revealed she had just been assigned to follow up on the GDRs and stated the residents were followed on their medication reviews by the Consultant Pharmacist, who was required to give a report when a GDR was needed. However, the DON had no record of a</p>	F 428	<p>Director reviewed all residents who receive antipsychotic medications to assure that a GDR had been addressed for each resident. All residents had no irregularities noted and are reviewed at least every six month.</p> <p><i>Measures or Systemic Changes Made to Avoid Reoccurrence</i> On 12/9/2015, the Administrator and the Behavior Committee whose members include the Director of Nursing, Assistant Director of Nursing, Consulting Pharmacist, Psychiatrist, and Social Service Director reviewed the policies and procedures of the Behavior Committee and the GDR. The Behavior Committee meets monthly. The policies and procedures include that the Pharmacist report any drug irregularities to the Attending Physician. On 12/9/2015, the Consulting Pharmacist was educated on the need to notify the Attending Physician on each resident who receives antipsychotic medications for a GDR and the need to document these needs in the Consulting</p>		

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NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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F 428	<p>Continued From page 13 recommended GDR by the Psychiatrist or the Consultant Pharmacist.</p> <p>Interview with the Consultant Pharmacist, on 11/19/15 at 2:50 PM, revealed he reviewed the charts monthly and looked for any changes and stated the antipsychotics should be reviewed for a possible GDR "every six months." The consultant stated he reviewed the psychologist's documentation on the resident, as the physician "was very thorough," and stated if the psychiatrist noted the resident was stable, the consultant "took that to mean he did not want a GDR."</p>	F 428	<p>Pharmacy reports and the medical record for each resident.</p> <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The Quality Assurance (QA) Committee that meets monthly will review the results of the monthly drug reviews related to antipsychotics by the Consulting Pharmacist and the Behavior Committee for follow-up and recommendations. The QA Committee meets monthly and includes the Medical Director, Administrator, Director of Nursing, Quality Assurance Nurse, Clinical Coordinator and Social Service Director.</p> <div style="border: 1px solid black; width: fit-content; margin: 10px auto; padding: 2px 10px;">12-19-2015</div>	12-19-2015
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NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance on 12/19/15, as alleged.	{K 000}			
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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NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, NY 13436
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1962 Remodeled: 1971 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (211) SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1962 and upgraded in 2008, with 35 smoke detectors and 32 heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 2007. EMERGENCY POWER: Type II Diesel Generator installed in 2007.</p> <p>A Life Safety Code Survey was initiated and concluded on 11/20/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty-nine (59) beds with a census of fifty-eight (58) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) at seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p>	
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>	K 144	<p><u>K 144 (SS=F) NFPA 101 LIFE SAFETY CODE STANDARD</u></p> <p><i>Corrective Action for Residents Found to Have Been Affected:</i> On 12/1/2015, the Maintenance</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Margaret B. Curtis* TITLE: *Administrator* (X6) DATE: *12-10-15*

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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K 144	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on an interview, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. This deficient practice affected four (4) of four (4) smoke compartments, staff and all the residents. The facility has the capacity for fifty-nine (59) beds with a census of fifty-eight (58) the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code Survey on 11/20/15 at 10:25 AM, an interview with the Director of Maintenance at the generator transfer switch panel revealed he was not aware he should be manually testing the generator transfer switch at the generator transfer switch panel on a monthly basis as required. This type of testing helps ensure the generator transfer switch is operating as intended.</p> <p>The findings were revealed to the Administrator on exit.</p> <p>Reference: NFPA 110 1999 edition</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a</p>	K 144	<p>Director is manually testing the generator transfer switch to ensure the generator transfer switch is operating as intended.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i> All residents have the potential to be affected by K 144. On 12/1/2015, the Maintenance Director is manually testing the generator transfer switch each month to ensure the generator transfer switch is operating as intended.</p> <p><i>Measures or Systemic Changes Made to Avoid Reoccurrence</i> The Maintenance Director has added the manual testing of the generator transfer switch to the monthly performance checks of the generator to ensure the generator transfer switch is operating as intended.</p>	

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K 144	Continued From page 2 transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144	<p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The Administrator will review the monthly manual testing of the generator transfer switch with the Maintenance Director each month.</p> <div style="border: 1px solid black; width: 100px; height: 30px; margin: 20px auto; text-align: center;">12-19-2015</div>	12-19-2015	