

Acceptable POC 7/13/13

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

PRINTED: 07/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/21/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-HARRODSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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)

F 000 INITIAL COMMENTS

An Abbreviated Survey to investigate KY00020281 was initiated on 06/19/13 and concluded on 06/21/13. The allegation was substantiated and deficient practice was cited at 42 CFR 483.10 Resident Rights, 42 CFR 483.20 Resident Assessment, and 42 CFR 483.25 Quality of Care. b The highest scope and severity was a "D".

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

This Plan of Correction is the center's credible allegation of compliance.
Preparation and the execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F157

July 13, 2013

F 157

Kindred Nursing and Rehabilitation - Harrodsburg will continue to immediately notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a)

The facility will continue to notify the resident and the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in 483.15(e)(2), or a change in resident rights under Federal or State law. The facility will continue to record and periodically update the address and phone number of the resident's legal representative or interested family member.

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

Michelle L. Johnson Executive Director 7-11-2013

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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The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Physician was notified when there was a change in status for one (1) of three (3) sampled residents. Resident #1 complained to the nurse of dry eyes and the inability to sleep at night. The nurse sent a notification to the Physician, who failed to respond. The facility failed to follow up on the notification for six (6) days.

The findings include:

Review of the facility's policy titled "Notifications", effective 04/28/13, revealed staff was to inform the Attending Physician when treatment needed to be altered.

Review of the clinical record revealed the facility admitted Resident #1 on 03/18/13 with diagnoses which included Dementia, Anxiety, Depression and Allergic Rhinitis.

Interview, on 06/19/13 at 10:00 AM, with Resident #1 revealed Resident #1 had requested the nurse obtain an order for eye drops "over a week ago". The resident stated he/she was already taking a sinus pill, but needed something else to manage the symptoms. Continued interview revealed the

F 157 1. The MD was notified for resident #1 on 6/19/2013 and new orders received.

2. An audit was conducted by the DNS on all residents' nurses' notes on 6/1/2013 to 7/9/2013 to ensure that all notifications for any changes of condition were made.

3. All licensed staff was educated by the Staff Development Coordinator and/or UM's and DNS on 6/21/2013 to 7/12/2013 to place an alert on resident's dashboard for notification follow-ups. An MD response log was put in place to ensure that all notification is followed up timely.

4. The DNS and/or UM and/or RN Weekend Supervisor will review the MD response log weekly to ensure that all notifications were followed up timely for 3 months.

The DNS and/or Executive Director or designee will bring any concerns identified to the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further interventions/corrective actions will be implemented as necessary.

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the nurse told the resident she would call the doctor about some new orders. The resident further stated the doctor never called back.

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Review of nursing documentation, dated 06/13/13 at 3:53 PM, revealed Licensed Practical Nurse (LPN) #1 sent a fax to the Physician for "eye gtts (drops) and a sleep med per resident request". Continued review revealed no new orders had been received at the time the documentation was entered.

Interview with LPN #1, on 06/21/13 at 9:25 AM, revealed she had sent a fax to the Physician on 06/13/13, requesting the eye drops and a sleeping pill for Resident #1. She stated she had not heard back from the Physician by the end of the day. She further stated she would have made another attempt to reach the Physician if the resident had continued to complain. On further interview, LPN #1 stated she reported to the oncoming shift about the resident's request and that the Physician had not yet responded. Continued interview revealed LPN #1 did not receive any information during shift report regarding the resident's complaint when the nurse returned to work after three (3) days off. She stated Resident #1 did not complain again until 06/19/13, when LPN #1 again notified the Physician and received orders for eye drops and Benadryl (may be given for allergy symptoms and/or to promote sleep). LPN #1 stated there was not a formal system for follow up with the Physicians when requests were made.

Interview with the Director of Nursing (DON), on 06/21/13 at 12:25 PM, revealed she was not aware there had been a six (6) day delay in

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obtaining a response from the Physician regarding Resident #1's request for medications. She stated the nurse should pass any pending requests along during shift report. She stated the facility did not keep any log of notifications or have a formal system for follow up. She further stated it was a matter of nursing judgment.

F 157: *This Plan of Correction is the center's credible allegation of compliance.*

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F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

F 281, F281

Kindred Nursing and Rehabilitation - Harrodsburg will continue to provide services that meet professional standards of quality by gathering information within twenty-four (24) hours of admission "to assess the resident's preliminary physical and mental needs". Information obtained from the assessment will be care planned sufficient to meet the resident's needs.

1. Resident #1 care plan was updated to on 6/21/2013 by the IDT reflect the resident's current plan of care.
2. An audit was conducted by the Case Manager on 7/18/2013 on all new residents that had not gone through the RAI comprehensive care planning process. Any concerns identified with care plans not reflecting the resident assessments conducted were corrected at that time.
3. All licensed staff was educated by the Staff Development Coordinator and/or LJM's and DNS on 6/21/2013 to 7/12/2013 on the initial care planning process for new admission to ensure resident care plans reflect residents current plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to meet professional standards of quality for one (1) of three (3) sampled residents. There was no documented evidence of assessment and care planning sufficient to meet the needs of a newly admitted resident (Resident #1), prior to completion of the first comprehensive assessment and comprehensive care plan.

The facility admitted Resident #1 on 03/18/13. Resident #1 exhibited significant behaviors on 03/19/13, one day after admission to the facility. On 03/23/13, Resident #1 exhibited behaviors which resulted in the administration of Haldol (a hypnotic medication) and subsequent transfer to an inpatient behavioral health unit. In addition, Resident #1 had a diagnosis of Lower Back Pain and a ten-year history of narcotic pain medication use. The initial care plan did not address the

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resident's behaviors or the potential for inadequate pain management.

The findings include:

Review of the policy titled "Initial Resident Assessment", dated 04/28/09, revealed information was to be gathered within twenty-four (24) hours of admission "to assess the resident's preliminary physical and mental needs". Continued review revealed assessment data was collected and analyzed by various disciplines as appropriate, including Nursing and Social Services. Examples of data to be collected included behavioral patterns. Further review revealed an initial care plan was to be initiated as appropriate, based on the resident assessment.

Review of the Primary Care Physician's records, on which the admission orders were based, revealed Resident #1 had a diagnosis of Chronic Lower Back Pain. Pre-admit medications included Lorcet 10 milligrams (mg) twice daily. (Lorcet is a narcotic pain reliever.)

Review of the clinical record revealed Resident #1 was admitted by the facility on 03/18/13 with diagnoses which included Dementia, Anxiety and Depression. The diagnoses list did not include Chronic Lower Back Pain.

Review of the Admission Orders Record revealed all pre-admit medications were continued, including Lorcet 10 mg twice daily.

Review of the Pain Assessment, dated 03/18/13, revealed Resident #1 verbalized pain which was chronic in nature, at a level of two (2) on a scale

F 281 4. A care plan audit tool was developed to ensure that each resident care plan reflects the residents individualized current plan of care and review all new admission care plans to ensure they reflect the residents current plan of care will be conducted through the IDT which consists of the ED, DNS, UM's, Social Service Director, Activity Director and Dietary Manager in morning meeting Monday through Friday with the RN Weekend Supervisor reviewing on Saturday and Sunday.

The DNS and/or Executive Director or designee will bring any concerns identified with the care plan audits to the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further interventions/corrective actions will be implemented as necessary.

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of one (1) to ten (10), and the resident exhibited facial grimacing.

Review of the initial care plan revealed no interventions related to pain were initiated prior to 04/04/13.

Interview with Resident #1, on 06/19/13 at 10:00 AM, revealed he/she had three (3) back surgeries in the past and had been on pain medications for about ten (10) years.

Review of the Behavior Monitoring Log for March 2013 revealed Resident #1 began exhibiting behaviors within twenty-four (24) hours of admission. Continued review revealed the behaviors occurred daily and included hallucinations, delusions, physical and verbal actions directed toward others, e.g. hitting and screaming, disrobing in public, and wandering.

Review of the form "Determining Cause of Disruptive Behavior" revealed it was utilized once on 03/18/13, four (4) times on 03/19/13, and once again on 03/23/13 (six total). Behaviors described included wandering, thinking other residents were family members, rummaging in other residents' personal belongings, walking naked in the hallway, and cursing and hitting staff members. Review of documentation for "Possible Triggers" revealed the following: I don't know; probably sundowning; who knows; do not know; new place; dementia/wandering; and wants to go home.

Further review of the initial care plan revealed no interventions related to identified resident behaviors were initiated.

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F 281:

Review of Social Services documentation, dated 03/19/13 at 2:55 PM, revealed she had received the "Determining Cause of Disruptive Behavior" forms. Continued review revealed the nurse had agreed to notify the Physician and the family about Resident #1's behaviors. The Social Worker further noted she would "follow up as needed to ensure psychosocial wellbeing". Continued review revealed no follow up note was documented prior to Resident #1 being transferred to the behavioral health facility for inpatient evaluation.

Review of nursing documentation for 03/19/13 revealed no documented evidence the Physician or the family was notified of Resident #1's behaviors. Attempts to interview the nurse revealed she was no longer employed at the facility and the facility did not have a working phone number.

Interview with the Social Services Director, on 06/20/13 at 3:53 PM, revealed she was responsible for the residents' behavioral health care plans. She stated, based on Resident #1's behaviors, she should have initiated a care plan. Continued interview revealed she recalled speaking to the nurse, who was no longer employed at the facility, about notifying the Physician of the behaviors. She further stated she did not know if the nurse had made the notification or not.

Interview with the Director of Nursing (DON) and the Unit Manager (UM) where Resident #1 resided, on 06/21/13 at 12:25 PM, revealed they had no recollection of a discussion of Resident

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#1's behaviors during the daily interdisciplinary meetings. The UM stated she was not sure if the initial care plan would have included interventions related to behaviors. She further stated the Social Worker was responsible for evaluating resident behaviors and initiating a care plan. The DON stated the initial care plan was based on the resident's diagnoses and information obtained from the nursing evaluation, and was a matter of professional nursing judgment. She stated she did not know why Chronic Lower Back Pain was not included in Resident #1's admission diagnoses. However, she stated she would expect to see a care plan for pain based on a diagnosis of Lower Back Pain and a ten-year history of narcotic pain medication use.

F 329: 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=D

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.

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

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F329

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Kindred Nursing and Rehabilitation Harrodsburg will continue to provide a drug regimen that is free from unnecessary drugs. The facility will continue to develop a care plan with specific interventions based on an assessment of the resident's behaviors. The facility will continue to notify the physician and resident's legal representative or an interested family member when a significant change in the resident's physical, mental, or psychosocial status occurs.

F 329

1. Resident #1 medications were reviewed by the IDT on 6/21/2013 and by the MD on 7/10/2013 and resident is free from all unnecessary medications.

2. An audit was conducted by the Case Manager, MDS Coordinator and UM's and/or DNS on all residents on anti-psychotic medications to ensure the resident's care plans had addressed behaviors exhibited and person centered interventions are in place. Also audited were behavior logs, acknowledgments forms and appropriate diagnoses.

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contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure each resident's drug regimen was free from unnecessary drugs, for one (1) of three (3) sampled residents (Resident #1). Resident #1 exhibited behaviors over the course of six (6) days, with no documented evidence the behaviors were assessed or analyzed for root cause. The facility failed to develop a care plan with specific interventions based on an assessment of the resident's behaviors. In addition, there was no evidence the Physician was notified of the behaviors prior to the sixth day, when an order for Haldol was received and the hypnotic drug was administered to the resident.

The findings include:

Review of the facility's policy titled "Psychoactive Drug Use", dated 01/28/11, revealed the policy was designed to ensure underlying causes of behavioral symptoms were identified and treated prior to the medical necessity of a psychoactive drug. Continued review revealed the facility was to attempt to identify possible reasons for the patient's distress and develop a care plan individualized to the resident's needs. Continued review revealed staff was to obtain a signed

F 329 3. All licensed staff was educated by the Staff Development Coordinator and/or UJM's and DNS on 6/21/2013 to 7/12/2013 on the care plan process to ensure the care plan reflects the residents current plan of care and proper notification of ED and/or DNS upon receipt for an order for a PRN anti-psychotic.

4. All new orders will be reviewed through the IDT morning meeting Monday through Friday with the RN Weekend Supervisor reviewing on Saturday and Sunday.

The DNS and/or Executive Director or designee will bring any concerns identified to the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further interventions/corrective actions will be implemented as necessary.

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"Acknowledgment of Psychoactive Medication Use" form after receiving a Physician's order for a psychoactive medication.

Review of the facility's policy titled "Initial Resident Assessment", dated 04/28/09, revealed information was to be gathered within twenty-four (24) hours of admission "to assess the resident's preliminary physical and mental needs". Continued review revealed the assessment should include an analysis of behavioral patterns to determine individual needs and preferences.

Review of the clinical record revealed the facility admitted Resident #1 on 03/18/13 with diagnoses which included Dementia, Anxiety and Depression.

Review of the Behavior Monitoring Log for March 2013 revealed Resident #1 began exhibiting behaviors beginning the night of admission, 03/18/13. Continued review revealed the behaviors occurred daily until the resident was transferred to the behavioral management unit for inpatient treatment. The documented behaviors included hallucinations, delusions, physical and verbal actions directed toward others, e.g. hitting and screaming, disrobing in public, and wandering. Documented interventions were limited to consoling the resident, removing the resident from the area, and ensuring personal needs were met. Further review revealed these interventions were effective only for a short time.

Review of the form "Determining Cause of Disruptive Behavior" revealed it was utilized six (6) times between 03/18/13 and 03/23/13. Behaviors described included wandering,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/21/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-HARRODSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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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delusions that other residents were family members, entering other resident rooms and getting into their personal items, removing his/her clothes and walking in the hall, yelling and cursing, and striking out at staff members. Continued review of the form's section for "Possible Triggers" revealed the following responses: I don't know; probably sundowning; who knows; do not know; new place; dementia/wandering; and wants to go home.

Review of the Care Plan revealed no documented evidence the exhibited behaviors had been addressed and no specific interventions were initiated.

Review of the Social Worker's note, dated 03/19/13 at 2:55 PM, revealed she had received three (3) "Determining Cause of Disruptive Behavior" forms. Continued review revealed the SW talked to the nurse (Nurse A), who agreed to notify the Physician and the family about Resident #1's behaviors. Continued review revealed the Social Worker further noted she would "follow up as needed to ensure psychosocial wellbeing"; however, there was no documented evidence a follow up was provided.

Review of nursing documentation for 03/19/13 revealed no documented evidence Nurse A contacted the Physician or the family regarding Resident #1's behaviors. Attempts to interview Nurse A revealed she was no longer employed at the facility and the facility did not have a working phone number for her.

Interview with the Social Services Director (SSD), on 06/20/13 at 3:53 PM, revealed The

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"Determining Cause of Disruptive Behavior" form could be filled out by any nurse and forwarded to the SSD for review. She stated she attempted some interventions, including distraction with activities and reminiscing, without success. She acknowledged she had no documented evidence of attempts to determine a root cause of the behaviors and had depended on Nurse A to communicate with the family and the Physician. She stated she was responsible for the residents' behavioral health care plans and should have initiated a care plan related to Resident #1's specific behaviors. Continued interview revealed she was unable to provide any evidence of follow up to the "Determining Cause of Disruptive Behavior" forms.

Review of the Nurses Notes revealed Licensed Practical Nurse (LPN) #3 documented, on 03/23/13 at 2:17 PM, Resident #1 was increasingly agitated and combative and could not be redirected. Review of the note dated 03/23/13 at 2:27 PM, revealed the Physician was notified and an order for Haldol 1 milligram was received and the drug was administered. Review of subsequent documentation by LPN #3, on 03/23/13 at 5:29 PM, revealed upon reporting administration of the Haldol to the family, he was told the resident should not have received the drug as the resident had a bad reaction to it in the past.

Interview with LPN #3, on 06/20/13 at 8:41 PM, revealed the family he spoke to about the Haldol was very upset Resident #1 had received it. He stated he looked throughout the resident's chart but found no indication the Haldol was not to be given, or had ever been given with adverse

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consequence. He further stated he had not notified the family or obtained an "Acknowledgment of Psychoactive Medication Use" form consent. He stated everything happened too fast.

Interview with the Director of Nursing (DON) and the Unit Manager (UM) where Resident #1 resided, on 06/21/13 at 12:25 PM, revealed they had no recollection of a discussion of Resident #1's behaviors during the daily interdisciplinary meetings. The UM stated she was not sure if the initial care plan should have included interventions related to behaviors. She further stated the Social Worker was responsible for evaluating resident behaviors and initiating a care plan. The DON stated the initial care plan was based on the resident's diagnoses and information obtained from the nursing evaluation, and was a matter of professional nursing judgment. She further stated she knew of the family being upset about the resident being given Haldol only after the fact. Additionally, she stated the facility had no record at the time of Resident #1's admission to indicate the resident was not to receive Haldol prior to the incident. Continued interview revealed the drug was not one of the listed allergies on admission and the facility could only proceed with the information made available to them on admission of the resident.

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