

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

PRINTED: 03/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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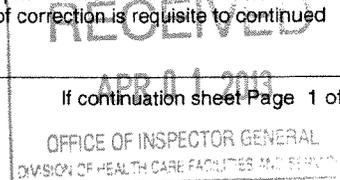
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F 000	INITIAL COMMENTS A special focus health survey was conducted on March 5-7, 2013 and a Life Safety Code survey was conducted on March 7, 2013. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct before remedies would be imposed. KY19805 and KY19806 were investigated in conjunction with the survey and the Division of Health Care found the allegations to be unsubstantiated with no regulatory violations.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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.</i>	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of the facility's policy, it was determined the facility failed to assure Nursing students knocked on the residents' doors and requested permission to enter before doing so. The findings include: Review of the facility's policy regarding Quality of Life, with a release date of April 20, 2012, revealed care was to be provided in a manner and environment that maintained or enhanced each patient's dignity and respect in full recognition of his or her individuality. The	F 241	F 241 1) Nursing instructors were informed of the issue of their nursing students' failure to knock on resident room doors and ask permission to enter the resident's room before actually entering on 3/7/13 by the Staff Development Coordinator. Nursing students were inserviced regarding dignity and knocking before entering resident rooms on 3/7/13 and 3/8/13 by Staff Development Coordinator. On 3/20/13 the Staff Development Coordinator inserviced nursing students regarding quality of life (dignity), in particular knocking on resident room doors and waiting for permission to enter. This inservice will take place again on 4/2/13 with the next group of	April 15, 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marcella Hodges</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>3/29/13</i>
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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.

BJB



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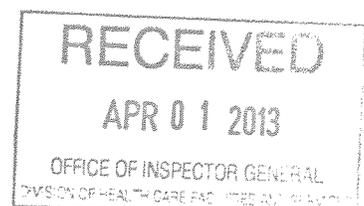
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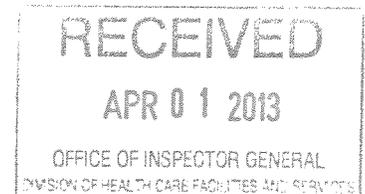
F 241	Continued From page 1 patient's private space and property were to be treated with respect; with examples of asking permission to move or inspect personal clothing, knocking on doors before entering the room, requesting permission to enter, closing doors as requested by the patient, and not changing stations on television or radio without asking permission. Review of the Resident Council minutes, dated 01/25/13, revealed residents expressed a concern that the staff was not knocking on the doors and announcing themselves before entering the room. 1. Observations, on 03/06/13 at 12:30 PM, revealed a nursing student walked into room 150 without knocking before entering the resident's room. Additionally, eight (8) nursing students on the E Hall were observed entering the residents' rooms without knocking or asking permission to enter while they were delivering lunch trays. Additional observation, on 03/07/13 at 9:40 AM, revealed a nursing student walked into room 148 without knocking on the door and requesting permission to enter. Observations, on 03/06/13 at 12:30 PM, on the E Hall revealed nursing student #1 and #2 entered room 148 without knocking. Interview with the two nursing students, on 03/07/13 at 1:00 PM, revealed they knew they were suppose to knock and wait for a response before they entered a resident's room. 2. Observations, on 03/07/13 at 10:10 AM,	F 241	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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.</i> nursing students. 2) All residents have the potential to be impacted by this practice. 3) Beginning April 1, 2013, before nursing students are allowed to interact with residents at Kindred Transitional Care and Rehabilitation Rosewood, they will be required to attend a basic training that includes respecting resident dignity, including knocking on doors and asking permission before entering resident rooms. This training will be lead by the facility Staff Development Coordinator and/or the Director of Nursing and /or Assistant Director of Nursing in the event the DNS/SDC are unavailable. Facility staff will continue to be inserviced regarding dignity semi-annually and as needed.	
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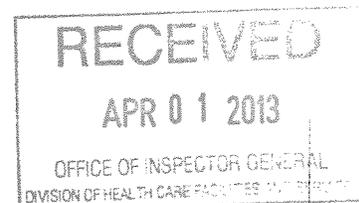
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F 241	Continued From page 2 revealed a nursing student walked into room 109 without knocking before they entered the resident's room and at 10:25 AM and 10:35 AM, nursing students entered rooms 129 and room 125 without knocking and waiting for permission to enter. Interview with the Director of Nursing, on 03/07/13 at 2:15 PM, revealed the problem had been brought to her attention and she had spoken to the clinical nurse instructors who were responsible for the nursing students. She stated nursing students have been through the nurse aide training and know they are suppose to knock on a resident's door before entering.	F 241	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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.</i>	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	4) The DNS, ADNS, Unit Managers, Staff Development Coordinator and Executive Director will make daily random observations to ensure nursing students and facility staff are observing resident dignity by knocking on doors and asking permission to enter resident rooms. Any concerns identified will be addressed at that time. The result of theses observations will be reported to the monthly Performance Improvement meeting by the DNS monthly for a period of three months and quarterly thereafter until substantial compliance is met. F 280 1. The care plan of Resident #6 was reviewed and revised to include new	April 15, 2013



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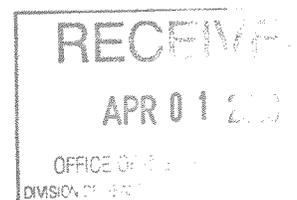
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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to revise a care plan for one (1) of twenty-four (24) sampled residents and two unsampled residents, (Resident #6) for supervision of meals. The findings include: Review of the facility's policy, titled Care Plans, with a release date of January 7, 2012, revealed the team of qualified persons were to monitor the patient's condition and effectiveness of the care plan interventions. The care plan is revised quarterly, annually, with a significant change assessment or more frequently as needed with input by the patient and/or the representative, to the extent possible, (or justified the continuation of the existing plan) based upon the following: the care plan has treatment objectives with measurable outcomes that are prioritized and used to monitor patient progress. The plan of care is to include directives for managing care and should be revised and updated as necessary to reflect the individuals current status. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 05/04/12 with a diagnosis of Failure to Thrive. The physician orders identified Remeron 15 mg was ordered daily for Depression and poor appetite. Ensure Plus, three (3) times a day at medication pass for weight loss was also	F 280	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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.</i> Speech Therapy recommendations for supervision of meals. 2. All residents have the potential to be affected by this practice. The care plans of all residents will be reviewed and revised as necessary to ensure accuracy and implementation of care plan interventions, particularly supervision of meals, to reflect the residents' current status. 3. The care plan team will continue to review and update care plans quarterly, annually and with a significant change. The care plan will be updated with daily changes by the Unit Managers with new physician orders and recommendations from therapy. These daily changes will be reviewed as part of		



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F 280	<p>Continued From page 4 included. Review of Resident #6's care plan revealed the facility had identified the resident as having a swallowing impairment related to Dysphagia. The goals identified were the patient would feed self utilizing safe swallowing strategies. The care plan was initiated on 08/01/12, revised on 09/05/12 and had a target date of 03/05/13. Interventions indicated the staff were to encourage the resident to alternate bites of food with sip of liquid; encourage resident to massage his/her right cheek as they chewed, and encourage to swallow two (2) times with each bite of food. The CNA, LPN, and RN were identified as responsible for the care. The CNA care plan reiterated the same directions.</p> <p>Observations, on 03/06/13 at 12:40 PM, revealed Resident #6 was sitting up in the bed with a tray of food on the bedside table. Resident #6 was observed to tear a grilled cheese sandwich into parts. The resident took a bite and returned it to the plate. The resident took a bite of chocolate ice cream then proceeded to drink the chocolate milk and took a bite of a cookie. No one entered the room to encourage the resident to eat, no one prompted or encouraged the resident to alternate a bite of food with a sip of liquid or to swallow two times with each bite of food. No one encouraged the resident to massage the right cheek as the resident chewed the food. None of the care plan interventions were implemented.</p> <p>Interview, on 03/06/13 at 12:55 PM with LPN #3, revealed the resident only needed to be set up for meals. She stated staff was to be present during meals to supervise back in August (2012). She stated speech had recently evaluated the resident and placed the resident back in therapy services</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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.</i></p> <p>the morning stand up meeting by the Interdisciplinary Team (IDT) as well. Unit Managers will ensure these changes are implemented.</p> <p>4. 10% of care plans will be audited monthly by the IDT to ensure they are updated to reflect the resident's current status. Any problems identified will be corrected at that time. The result of these audits will be brought to the monthly Performance Improvement meeting by the DNS to be reviewed monthly for a period of three months and quarterly thereafter until substantial compliance is met.</p>		



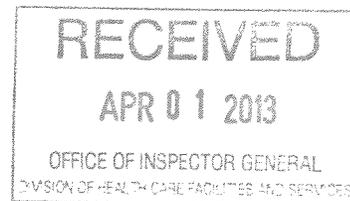
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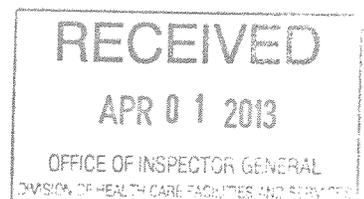
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F 280	<p>Continued From page 5</p> <p>due to weight loss. She stated she thought the resident was safe to eat alone; however, she did not realize the care plan directed staff to encourage the resident to take small sips between bites of food.</p> <p>Interview, on 03/06/13 at 2:30 PM, with the Speech Therapist revealed the care plan goals and objectives for Resident #6 were old and had not been revised. She stated she had picked the resident up a couple of weeks ago after a referral for decreased PO intake had been identified. She stated she had assessed the resident as safe to eat alone and the resident would eat what ever he/she liked. She stated it would vary from day to day. She revealed therapy had given nursing the recommendations; however, no one had discussed care plan interventions with her. She stated the therapists did not make revisions to the care plan, only recommendations.</p> <p>Interview, on 03/06/13 at 4:20 PM, with Unit Manager LPN #2 revealed if the therapists wanted to change a recommendation they would bring them to the care plan conference and identify their recommendations. She stated the nurses would then revise the care plan. She revealed she had not been in the resident's room at mealtime to observe the resident during meals and she had not checked with the nurse aides to verify if they had or had not supervised the resident's meal. She stated the care plan interventions were not appropriate for the resident. Her understanding was Speech Therapy was still working with the resident and in their minds they had done what was required. She said the nurses were responsible to ensure the care plans were revised and updated as necessary.</p>	F 280		



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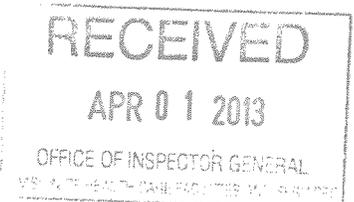
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F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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.</i></p> <p>F 431</p> <p>1. The refrigerator on the North Wing was replaced on 3/6/13. All medications stored in this refrigerator were discarded properly and replaced. The temperature was adjusted and the refrigerator was not used to store medications until it was reading an appropriate temperature for medication storage.</p> <p>The refrigerator on the South Wing had the temperature adjusted and monitored until it maintained the proper temperature for medication storage.</p>	April 15, 2013	
	<p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p>				



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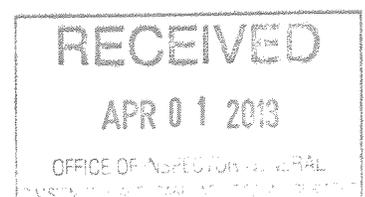
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F 431	Continued From page 7 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to store medication under proper temperatures in two (2) of two (2) medication refrigerators (North and South Units), failed to assure expired needles and Angiocath were removed from use in one (1) of two (2) medication rooms (North Unit) and failed to assure all biologicals on treatment cart #1 were labeled and dated when opened. The findings include: Review of the facility's policy regarding Monitoring Temperatures of Refrigerators and Freezers, dated 10/31/10, revealed the staff was to take and record temperature readings for refrigerators and freezers using the internal thermometer reading at least twice daily. Report out of range levels immediately to the Nutrition Services Manager or designee and normal refrigerator temperatures should range from 34-38 degrees. Although the facility was unable to provide a specific policy relating to expiration of Angiocath or needles, the facility provided a policy relating to Medication Labels and Packaging, dated 10/31/09, which revealed the staff was to discard medications by the expiration date unless indicated by the pharmacy and/or manufacturer's instructions to discard sooner. 1. Review of the North Unit refrigerator, on 03/07/13 at 7:00 AM, revealed a temperature at ten (10) degrees. Observation of the liquid medications, stored inside the refrigerator, revealed the medication was frozen. Review of the contents of the refrigerator revealed the	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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.</i> Medications stored in that refrigerator were removed temporarily and placed in another refrigerator at the proper temperature until temperatures in the refrigerator on the South Wing were maintained at the correct level. The expired needles and Angiocaths found in the North Wing medication room were discarded on 3/7/13. The unlabeled, undated biologicals found on Treatment cart #1 were discarded and replaced on 3/7/13. They were dated and labeled when replaced. 2. All residents in the facility have the potential to be affected by this practice.		



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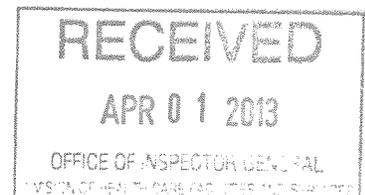
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F 431	Continued From page 8 following medications: 1)One (1) bottle of Pneumovax; 2) six (6) doses of flu vaccines 3) four (4) bottles of liquid Lansoprazole; 5) four (4) bottles of liquid Omeprazole; 6) nine (9) bottles of Insulin; 7) one (1) Combivent inhaler; 8) three (3) bottles of Engerix; 9) four (4) boxes of Procrit; 10) six (6) packages of Tylenol suppositories, and 11) four (4) packages of Dulcolax suppositories. Interview with the North Unit Manager, on 03/07/13 at 8:00 AM, revealed the refrigerator temperatures should be monitored in the morning and the evening, and recorded on the temperature log. The Unit Manager stated the refrigerator had stopped working, on 03/06/13, and was reported to maintenance, who replaced the refrigerator with a new one around 2:00 PM, on 03/06/13.	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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.</i> 3. Education will be completed with licensed staff regarding checking temperatures on the medication storage refrigerators daily and reporting to the Unit Managers when temperatures are out of range. Unit Managers will be responsible for re-checking the temperature and filling out a maintenance request if needed. Education will also be provided to licenses staff regarding the dating and labeling of medications and biologicals as they are opened and checking lab supplies, needles and Angiocaths to ensure they are not outdated. A new log has been implemented to record the temperatures of the medication refrigerators.
	Review of the refrigerator temperature logs, on 03/07/13, revealed there had been no temperature checks after the new refrigerator was replaced, and the word maintenance had been written across the 03/6/13 log dates, where the temperatures should be logged. Further interview with the Unit Manager, on 03/07/13 at 8:00 AM, revealed the medications had been placed into the new refrigerator, on 03/06/13 at 3:30 PM, but did not know why the temperatures had not been checked since that time. The Unit Manager revealed all the medications were frozen; however, revealed no residents had received any of these medications today. Interview with the Pharmacist, on 03/07/13 at 8:10 AM, revealed the facility had been instructed		



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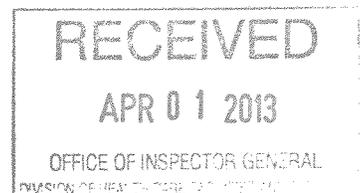
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW		STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(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
F 431	<p>Continued From page 9</p> <p>to take out all the medications, and allow thawing. The pharmacist revealed she would check each medication for use after freezing, and report back to the facility. The pharmacist later reported all the medications would need to be replaced.</p> <p>Interview with Assistant Director of Nursing, on 03/07/13 at 10:00 AM, revealed no residents had received any of the refrigerated medication and revealed the medication would not be given if found frozen. The ADON stated all the current insulin was currently stored in the medication cart at room temperature. The ADON also revealed that 11-7 shift was responsible for monitoring the temperatures, and if out of range temperatures are found, a maintenance request should be completed, and the medications moved to another refrigerator.</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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.</i></p> <p>The Weekend Supervisor will be responsible for checking medication rooms as part of her weekly duties to ensure all supplies are current and she will check all treatment carts to ensure all biologicals are labeled and dated. Any concerns will be addressed immediately.</p>	
	<p>Interview with the Director of Nursing (DON), on 03/07/13 at 3:15 PM, revealed the North Unit Manager had reported all the medications were frozen, and revealed the nurses on the floor should have monitored the temperatures prior to initially putting the medications in the refrigerator on 03/06/13. The DON revealed the expectation would be that the temperatures are checked daily, by the night shift, and reported to the dietary manager and nursing if abnormal. The DON stated the potential for complications for the freezing of medications might change the effectiveness of the medications, or properties, because medication had to be at a certain temperature to be stable.</p> <p>Interview with the ADON, on 03/07/13 at 3:15 PM, revealed there were seventeen (17) residents on the North Unit, and seventeen (17) residents on</p>		<p>4. Unit Managers, the ADNS and the DNS will conduct random observations of the medication rooms for expired lab supplies, needles and Angiocaths, temperature logs of the medication storage refrigerators and treatment carts as part of their daily rounds.</p> <p>The result of these rounds will be compiled and presented to the monthly Performance Improvement Committee meeting by the DNS or ADNS monthly for a period of three months and quarterly thereafter until</p>	



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F 431	<p>Continued From page 10 the South Unit requiring Insulin.</p> <p>2. Review of the North Unit Medication Room, on 03/07/13 at 8:00 AM, revealed observation of twelve (12) eighteen gauge Angiocath with expiration dates of January 2002, two (2) twenty-four gauge Angiocath with expiration dates of October 2010, and ten (10) twenty gauge needles with expiration dates of October 2011.</p> <p>Interview with the North Unit Manager, on 03/07/13 at 8:00 AM, revealed the Angiocath and needles should be discarded prior to the expiration dates.</p> <p>3. Review of the North Unit Treatment Cart #1, on 03/07/13 at 8:10 AM, revealed one (1) bottle of normal saline opened with no date or label, one (1) tube of wound dressing opened with no date, and one (1) tube of triple antibiotic ointment opened with no label or date when opened.</p> <p>Interview with the North Unit Manager, on 03/07/13 at 1:00 PM, revealed the nurses are responsible for monitoring the supplies, such as the needles or Angiocath, and the expired medications. In addition, the UM revealed the pharmacy consultant reviewed all medication and treatment carts on a monthly basis, when they completed the pharmacy reviews.</p> <p>Interview with the Director of Nursing, on 03/07/13 at 3:15 PM, revealed the nurses should be monitoring the expired supplies or medications in the treatment carts on weekends, and stated the weekend supervisor was responsible for checking for all expired medications.</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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.</i></p> <p>substantial compliance is met.</p>	



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F 431	Continued From page 11 4. Review of the South Medication Room Refrigerator Temperature Log revealed the temperatures for January, February and March 2013 ranged from twenty (26) degrees to thirty (32) degrees. The temperature guidelines on the log ranged from thirty (34) degrees to thirty-eight (38) degrees. Observation of the South Unit Medication Room refrigerator, on 03/06/13 at 9:00 AM, revealed a temperature at twenty-six (26) degrees. At 11:30 AM the temperature was (24) twenty-four degrees.	F 431		
	Observations of the contents of the South Unit Medication Room refrigerator, on 03/07/13 at 10:30 AM, revealed the following: one (1) bottle of liquid Omeprazole, two (2) bottles of liquid Lansoprazole, one (1) spray bottle of Fortical, four (4) Bisacodyl suppositories, four (4) Tylenol suppositories, one (1) vial of Pneumonia Vaccine, one (1) vial of Influenza Vaccine, and seventeen (17) vials of Insulin. Interview with South Unit Manager (SUM) LPN #2, on 03/18/13 at 8:14 AM, revealed the refrigerator temperatures are written in the log two (2) time a day by the nurses. The interview revealed LPN #2 checked the refrigerators daily to see if the refrigerator was cold; but did not look at the temperature logs and was unaware the temperatures were below the facility's			



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F 431	Continued From page 12 parameters. LPN #2 was also unaware of the facilities guidelines for the temperatures. Interview with SUM LPN #3, on 03/07/13 at 9:00 AM, revealed she did not monitor the temperature log; but did open the refrigerator daily to check to see if the refrigerator was cold. LPN #3 commented her concern was the refrigerator being cold enough; not too cold. LPN #3 was unaware of the facilities guidelines for temperature parameters and commented possibly at some time a medication could have become frozen.	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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.</i>	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F441	April 15, 2013

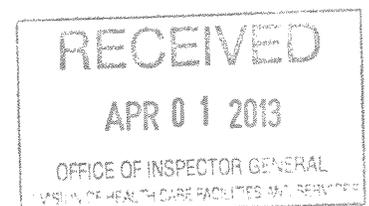
	(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a		1. Resident # 4 was not adversely affected by improper hand hygiene technique. Unsampled Resident B was not adversely affected by improper hand hygiene technique. 2. All resident's have the potential to be affected. 3. All Licensed Nurses were in service on appropriate hand hygiene procedure as it relates to conducting a skin assessment.	
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F 441	Continued From page 13 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure proper hand hygiene during medication administration and during resident contact for one (1) of twenty-four (24) sampled residents and one (1) of two (2) unsampled residents, Resident #4 and Unsampled Resident B. The findings include: Review of the facility's policy regarding Eye Drops, dated 10/31/10, revealed gloves were to be applied before administering eye drops. 1. Observation, on 03/06/13 at 8:10 AM, with Licensed Practical Nurse (LPN) #5 during medication pass with Unsampled Resident B revealed the nurse did not put on gloves before the administration of eye drops according to facility policy and procedure.	F 441	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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.</i> All Licensed Nurses and CMAs were in serviced on appropriate hand hygiene as it relates to Eye Drop Administration by the SDC.	
			The DNS, ADNS and UMs will conduct random audits of proper hand hygiene techniques being demonstrated by Licensed Nurses during skin assessments and by Licensed Nurses and Medication Aides during Eye Administration. The DNS/ADNS will report, track and trend audit findings to the PIC monthly for three months and quarterly thereafter until substantial compliance is met.	



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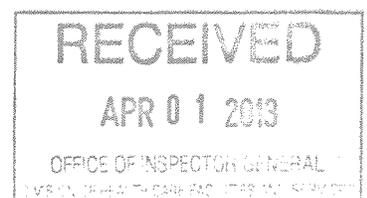
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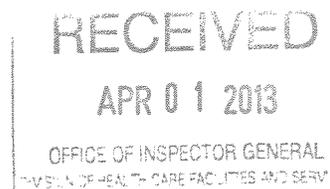
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F 441	Continued From page 14 Interview, on 03/06/13 at 8:40 AM, with LPN #5 revealed she was trained in nursing school to wash hands and to wear gloves whenever administering eye drops. LPN #5 commented she usually did not wear gloves when administering eye drops because the South Unit Manager told her to wash her hands before administering eye drops and did not mention to wear gloves; therefore, she thought she did not need to wear gloves in this facility when administering eyes drops. LPN #5 was unaware of what the facility policy was concerning the administration of eye drops and revealed not wearing gloves during eye drop administration could possibly spread germs. Interview, on 03/06/13 at 9:15 AM, with the South Unit Manager (SUM) revealed she was unsure what the facility's policy stated concerning wearing gloves during eye drop administration; but standard practice was to wear gloves. The SUM was uncertain why LPN #5 did not wear gloves during eye drop administration. The SUM commented this could spread germs. Interview, on 03/08/13 at 2:45 PM, with Registered Nurse (RN) #5, the Infection Control/ Staff Development Coordinator Nurse revealed it was standard nursing practice to apply gloves when administering eye drops. RN #5 revealed not wearing gloves during eye drop administration could spread germs. Interview, on 03/08/13 at 1:15 PM, with the Director of Nursing (DON) revealed it was the facility's policy to always wash hands and apply gloves before administering eye drops to a resident. The DON commented this could spread	F 441		



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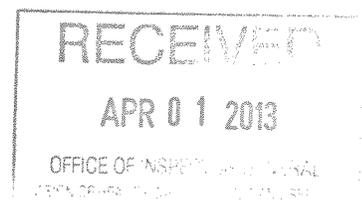
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F 441	Continued From page 15 microorganisms. 2. Review of the facility's Hand Hygiene/Handwashing policy, dated 08/31/11, revealed the staff was to change gloves during patient care if moving from a contaminated body site to a clean body site. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 05/05/00 with diagnoses of Paranoid Schizoid, Alzheimer Disease, Dementia with Behaviors and Pressure Ulcers. The facility completed a Quarterly Minimum Data Set (MDS) on 01/15/13 and assessed the resident as severely cognitively impaired. Observation of a skin assessment performed by Licensed Practical Nurse (LPN) #1, on 03/06/13 at 11:00 AM, revealed during the skin assessment LPN #1 placed her fingers into Resident #4's oral cavity and proceeded toward the peri-area, touching the indwelling catheter tubing and peri-area, then proceeded toward Resident #4's right knee, before changing her gloves. Interview with LPN #1, on 03/07/13 at 8:40 AM, revealed she should have changed gloves after going into the oral cavity and after touching the peri-area. Review of Licensed Practical Nurse Competencies for LPN #1, dated 06/28/12, revealed successful completion of return demonstration and knowledge of Hand Hygiene. Interview with Registered Nurse (RN) #1, on	F 441			



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F 441	Continued From page 16 03/7/13 at 11:20 AM, revealed she would have expected LPN #1 to change her gloves after touching Resident #4's oral cavity and peri-area.	F 441			



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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1961</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke and heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/07/13. Kindred Transitional Care & Rehab - Rosewood was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred seventy-six (176) beds with a census of one-hundred thirty four (134) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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.</i></p> <p>K062</p> <p>On March 18, 2013 an additional sprinkler head was added to Reflections shower room to ensure adequate sprinkler coverage in the Reflections shower room and a routine inspection of the sprinkler system was performed.</p> <p>All residents who reside in the Reflections Unit have the potential to be affected by this practice.</p> <p>Weekly rounds by the Director of Maintenance and/or the Executive Director will include observations for sprinkler coverage in all areas of the facility.</p> <p>The result of these rounds will be reviewed in the monthly Performance Improvement meeting by the IDT for a period of three months and quarterly thereafter until compliance is met.</p>	April 15, 2013
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Marcella Hodges* TITLE: *Executive Director* (X6) DATE: *3/29/13*

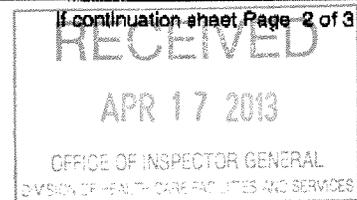
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	
(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
K 000	Continued From page 1 Fire)	K 000		
K 062 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinklers were maintained according to the NFPA requirements. This deficient practice affected one (1) of ten (10) smoke compartments, staff and twenty seven (27) residents. The facility has the capacity for 176 beds with a census of 134 on the day of survey. The findings include: Observations, on 03/07/13 at 10:30 AM, with the Director of Maintenance (DOM) revealed inadequate sprinkler coverage in the Reflections shower room. The walls in the shower room would prevent the sprinkler from reaching all areas in this room. Interview with the DOM, on 03/07/13 at 10:30 AM, revealed he was not aware of the improper sprinkler coverage. The findings were related to the Administrator at exit.	K 062		



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

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K 062	Continued From page 2 Reference: NFPA 13 1999 edition 5-5.5.1* Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard.	K 062			

