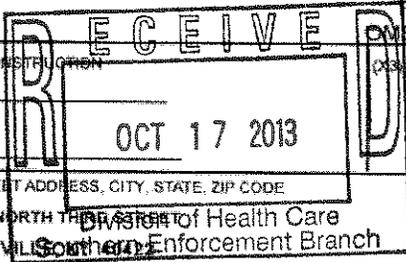


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-DANVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THE PLAZA DANVILLE, VA 22026
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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	INITIAL COMMENTS	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to provide maintenance and housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Observation during the environmental tour on 09/26/13 revealed the footboard in resident room 5-A had sharp plastic broken edges, one dining room table top was loose from the pedestal, and one fan in resident room 12-A was observed to be dirty and in need of cleaning.</p> <p>The findings include:</p> <p>An interview conducted with the Administrator on 09/26/13, at 2:35 PM, revealed the facility did not have a policy regarding maintenance work orders and repairs.</p> <p>A review of a facility policy titled, "5-Step Daily Patient Room Cleaning," dated 01/01/01, revealed staff was required to sanitize all horizontal surfaces daily using a solution of properly diluted germicide. The policy did not</p>	F 253	<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> <ol style="list-style-type: none"> Resident room 5-A's footboard was replaced with a new footboard and the dining room table in the Goldenrod Dining Room was fixed on 9/26/13. Resident room 12-A's fan was cleaned by the housekeeping manager on 9/26/13. On 10/02/13 the Maintenance Supervisor conducted an audit of resident head/foot boards in the facility to ensure there were no sharp edges. On 10/3/2013 the Maintenance Supervisor conducted an audit of all the facility dining room tables to ensure all were secure to the pedestal. On 9/30/13 the Housekeeping Supervisor conducted an audit of the fans in use in resident rooms to ensure all were clean. The Maintenance Supervisor will add head/foot board appearance and condition as well as table inspection to his weekly rounds to identify maintenance needs and develop a 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Director* (X6) DATE: *10-17-13*

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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F 253	<p>Continued From page 1 address the cleaning of fans.</p> <p>Observation during the environmental tour on 09/26/13, beginning at 8:30 AM, revealed:</p> <ul style="list-style-type: none"> -The footboard on the A bed in resident room 5 was observed to have sharp plastic broken edges. -A table in the Goldenrod Dining Room was observed to be loose from the pedestal and the table was unsteady. -The fan in resident room 12-A was observed to have gray dust all over the blades and was in need of cleaning. <p>An interview conducted with the Housekeeping Supervisor on 09/26/13, at 2:25 PM, revealed he made rounds daily as part of the Quality Assurance process to observe for any housekeeping concerns. The Housekeeping Supervisor stated the facility did not utilize work orders to notify the Housekeeping Department of housekeeping concerns but staff was required to call the Housekeeping Department. The Housekeeping Supervisor stated he had not been notified of and had not identified the dust on the fan in resident room 12-A.</p> <p>An interview conducted with the Maintenance Supervisor on 09/26/13, at 2:30 PM, revealed he conducted an environmental tour of the whole facility once a week as part of the Quality Assurance process and had not observed the identified concerns. The Maintenance Supervisor stated staff was required to complete a work order request, which was located at each nursing station, when a maintenance concern was</p>	F 253	<p>schedule to repair items noted during the rounds. The Housekeeping Supervisor will add fan cleanliness to his daily rounds to identify housekeeping areas that need attention by housekeepers. The Staff Development Coordinator, RN weekend Supervisor and the Executive Director will in-service staff on identifying and reporting maintenance needs including head/footboards and tables. The Executive Director, Maintenance Supervisor and Housekeeping Supervisor will conduct weekly environmental rounds to identify issues, trends or patterns and take corrective action as necessary.</p> <p>4. The Maintenance Supervisor and the Housekeeping Supervisor will present results of the weekly environmental rounds to the Performance Improvement Committee for three months or until the Committee determines compliance has been sustained. Members of the PIC include: Executive Director, Director of Nursing, Medical Director, Unit Managers, Social Services Director, Nutrition Services Manager, Activities Director, Staff Development Coordinator, Case Manager, Housekeeping Supervisor and Maintenance Supervisor.</p> <p>5. 10/21/2013</p>		

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F 253	Continued From page 2 identified. The Maintenance Supervisor stated the staff was then required to place the work order in a box at the nurses' station. An interview conducted with the Administrator on 09/26/13, at 2:35 PM, revealed she reviewed all maintenance work orders. The Administrator stated all maintenance concerns as well as housekeeping concerns were reviewed in the morning interdisciplinary meeting in which both the Maintenance Supervisor and the Housekeeping Supervisor were required to attend. The Administrator stated the facility had not identified the concerns.	F 253			
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 observation, interview, record review, and facility policy review, it was determined the facility failed to ensure services provided met professional standards of quality for two of twenty-one sampled residents (Residents #5 and #13). Resident #5 had physician's orders dated 08/29/13, to decrease the resident's Remeron (antidepressant) from 45 milligrams to 30 milligrams every night. However, a review of Resident #5's Medication Administration Records (MARs) for August and September revealed the order had been transcribed correctly on the August MARs and circled by the nurses as not given. However, a review of Resident #5's September MARs revealed from 09/01/13	F 281	1. Resident #5 Remeron dosage was corrected upon discovery and correct dosage administered 9/25/13. Resident #13 dressing was immediately changed upon discovery on 9/25/13 2. On 10/1/13 the licensed nurse Unit Managers conducted an audit of Medication Administration Record/Treatment Administration Record validation, to ensure all orders were carried over correctly and medications and treatments were administered according to physician's orders. The clinical team will review all orders Monday through Friday to ensure orders are transcribed correctly. 3. In-service/education was conducted by the Director of Nursing Service, Staff Development Coordinator, Unit Managers and RN Weekend Supervisor with facility clinical staff regarding: policy and procedures on medication errors, Pharmacy services, pharmacy		

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F 281	<p>Continued From page 3</p> <p>through 09/24/13, facility staff documented they had administered 45 milligrams of Remeron instead of the 30 milligrams as prescribed by the physician. In addition, interview and a review of documentation revealed the facility failed to provide dressing changes as ordered by the physician for a skin tear sustained by Resident #13.</p> <p>The findings include:</p> <p>1. A review of the facility's policy titled, "Verbal/Telephone Orders," dated 11/21/12, revealed after the nurse received a physician's order the nurse was then required to transcribe the physician's order to the MAR and fax a copy of the physician's order to the pharmacy.</p> <p>A review of a policy titled, "Renewed or Recapitulated Physician's Orders, Medication Records, and Treatment Records," dated 10/31/06, revealed every 30 days the facility would print in advance (no specific timeframe) the monthly MARs which were generated by the pharmacy, and they would then be reviewed by the nurse who was responsible for verifying the MARs' accuracy. The policy revealed the nurse was required to review the last 30-day orders with the current 30-day orders and any telephone orders received since the last 30-day orders. The nurse was required to print the MARs for the next month, review them with the physician's orders, and sign and date the MARs to validate that the orders were correct.</p> <p>A review of the medical record for Resident #5 revealed the facility admitted the Resident on 09/05/12, with diagnoses including Dementia, Depression, and Anxiety. A review of the</p>	F 281	<p>consultation, medication ordering and receiving, physician orders, medication transcription and recapitulation of orders. 10/01/2013 through 10/20/213.</p> <p>4. Review of physician's orders are being completed daily, Monday through Friday by the Director of Nursing Service and or unit managers to identify issues, trends or patterns and take corrective action as necessary. A monthly Medication Administration Record audit will be completed to validate medications have been transcribed/administered correctly by licensed Administrative nurses. A daily Treatment Administration Record audit will be performed x 4 weeks then weekly thereafter to validate treatments are being completed as ordered. This will be done by licensed Administrative nurses. Any trends will be taken to the monthly Performance Improvement Committee for three months or until substantial compliance is achieved and as needed thereafter. Members of the PIC include: Executive Director, Director of Nursing, Medical Director, Unit Managers, Social Services Director, Nutrition Services Manager, Activities Director, Staff Development Coordinator, Case Manager, Housekeeping Supervisor and Maintenance Supervisor.</p> <p>5. 10/21/2013</p>		

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F 281	<p>Continued From page 4</p> <p>physician's orders for Resident #5 revealed an order dated 08/29/13, at 11:45 AM, to decrease the resident's Remeron from 45 milligrams (mg) to 30 mg every night. A review of Resident #5's MARs for August 2013 also revealed documentation dated 08/29/13 to decrease the resident's Remeron from 45 mg to 30 mg every night. However, a review of the MARs for Resident #5 for September 2013 revealed the resident had received Remeron 45 mg every night beginning 09/01/13 through 09/24/13.</p> <p>Observation of Resident #5 on 09/24/13, at 12:05 PM, revealed the resident was sitting in a wheelchair with an alarm attached to his/her shoulder that would sound if the resident attempted to rise. Interview and observation revealed a family member of Resident #5 was sitting at the resident's chair side.</p> <p>Observation on 09/25/13, at 2:45 PM of the facility's medication cart revealed a medication drawer labeled for Resident #5. Continued observation revealed a box labeled Remeron 45 mg inside the drawer. The directions on the box of Remeron revealed the resident was to receive the medication every night.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 09/25/13 at 2:30 PM, revealed she had obtained the physician's order on 08/29/13 to decrease Resident #5's Remeron from 45 mg to 30 mg every night. The RN stated after obtaining the physician's order she transcribed the order onto the current August 2013 MARs, faxed a copy of the order to the pharmacy, and placed a copy in the pharmacy box, on the chart, in the medical records box to send to the physician to be signed, and in the Unit Manager's box to take to the</p>	F 281			

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F 281	<p>Continued From page 5</p> <p>morning meeting. The RN confirmed Remeron 45 mg was in Resident #5's medication drawer and available for administration at the time the review was conducted on 09/25/13.</p> <p>An interview conducted with Unit Manager #1 on 09/25/13, at 2:35 PM, revealed she was responsible for reviewing all current 30-day physician's orders and MARs. The Unit Manager stated she had completed the review prior to receipt of the new order received on 08/29/13 to decrease the resident's Remeron. The Unit Manager stated that at the time of the review she had obtained a copy of all new medication orders from the resident's medical records for the review. According to the Unit Manager, she should have identified the decrease in Resident #5's Remeron and corrected the September 2013 MAR.</p> <p>An interview conducted with the Registered Pharmacist (RPh) on 09/25/13, at 3:25 PM, revealed the pharmacy had not received the physician's order from the facility to decrease Resident #5's Remeron from 45 mg to 30 mg at night. The RPh stated he reviewed Resident #5's medical record on 09/15/13, and had also reviewed the physician's order sheets, but had not identified the error.</p> <p>An interview conducted with the Director of Nursing (DON) on 09/26/13, at 2:45 PM, revealed all new physician's orders were reviewed every day in the morning interdisciplinary meeting. The DON stated the Unit Managers were required to bring all new physician's orders to the meeting. The DON revealed after the Unit Manager had completed her review of the MARs for September 2013, she had locked them up in her office and</p>	F 281			

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F 281	<p>Continued From page 6</p> <p>they had not been available for RN #1 to transcribe the new order on for September 2013. The DON stated she was unsure how the order had been missed initially.</p> <p>2. A review of the medical record for Resident #13 revealed the facility admitted the resident on 01/30/13 with diagnoses including Cerebellar Vascular Accident, Generalized Pain, and Paralysis Agitans.</p> <p>A review of the physician's orders dated 09/21/13 for Resident #13 revealed staff was to complete dressing changes to a skin tear to the resident's left forearm on a daily basis. A review of the facility's treatment record for Resident #13 revealed the dressing was scheduled to be changed every day during the 7 AM to 3 PM shift.</p> <p>An observation of a skin assessment conducted by Licensed Practical Nurse (LPN) #2 on 09/25/13 at 12:25 PM revealed the resident had a dressing to a skin tear on the left forearm dated 09/22/13, two days prior to the observation.</p> <p>An interview conducted with LPN #2 revealed she had been assigned to provide care to Resident #13 on 09/23/13 and 09/24/13 during the 7 AM to 3 PM shift. However, LPN #2 stated she was not aware of the dressing changes listed on the treatment sheet for Resident #13 and, as a result, had not changed the resident's dressing on those dates.</p> <p>An interview conducted with the Unit Manager on 09/25/13 at 3:10 PM, revealed she reviewed treatment sheets and made rounds to monitor resident care three times a week. According to the Unit Manager, at the time of the interview on</p>	F 281			

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F 281	Continued From page 7 09/25/13 she had not reviewed the treatment sheets and was not aware Resident #13's dressing had not been changed as ordered by the physician.	F 281			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the drug regimen was free from unnecessary drugs for	F 329	1. Resident #8 medication Zoloft, per pharmacy recommendation signed by the resident's physician, was decreased as ordered to 50mg per day on 9/25/2013. 2. On 10/01/13, the licensed nurse Unit Managers and the licensed nurse Medical Records Director completed an audit of all charts to ensure that signed pharmacy recommendations were carried over correctly to Medication Administration Records'. The clinical team will review returned pharmacy recommendations daily Monday through Friday to ensure the drug regimen is free from unnecessary drugs. 3. In-service/education was conducted by the Director of Nursing Services, Staff Development Coordinator, Unit Managers and RN Weekend Supervisors with facility clinical staff regarding: policy and procedures on medication errors, pharmacy services, pharmacy		

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F 329	<p>Continued From page 8</p> <p>one of twenty-one sampled residents (Resident #8). A review of documentation revealed the pharmacist made a recommendation on 07/12/13 to Resident #8's physician to gradually reduce the prescribed dose of 100 milligrams of Zoloft (antidepressant) a day to 50 milligrams of Zoloft a day. Documentation revealed the resident's physician agreed with the pharmacist's recommendation on 07/26/13. However, observation of the Medication Administration Record on 07/26/13 for Resident #8 revealed facility staff continued to administer 100 milligrams of Zoloft to Resident #8, on a daily basis, from 07/26/13 to 09/25/13, a period of two months.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Pharmacist Consultation," with a revision date of 08/31/12, revealed a pharmacist would conduct a review of medications at least every 30 days or more often as needed. Further review of the policy revealed the physician and the Director of Nursing, or the designated licensed nurse, would address and document actions taken regarding the recommendations.</p> <p>A review of the medical record for Resident #8 revealed the pharmacist had made a recommendation to the physician to decrease Resident #8's Zoloft from 100 milligrams (mg) a day to 50 mg a day. Documentation revealed the resident's physician agreed to the pharmacist's recommendation on 07/26/13. A review of Medication Administration Records (MARs) for August 2013 and September 2013 revealed facility staff continued to document that 100 mg of Zoloft was administered to Resident #8. There</p>	F 329	<p>consultation, physician orders, pharmacy recommendations, medication transcription and recapitulation of orders. 10/01/2013 through 10/18/2013.</p> <p>4. Reviews of the pharmacy recommendations are being completed monthly upon return from the Physician. A monthly audit of the signed physician recommendations will be completed to validate that the identified residents' drug regimen is free from unnecessary drugs. Any trends will be taken to the monthly Performance Improvement Committee (PIC) for three months or until substantial compliance is achieved and as needed thereafter. Members of the PIC include: Executive Director, Director of Nursing, Medical Director, Unite Managers, Social Services Director, Nutrition Services Manager, Activities Director, Staff Development Coordinator, Case Manager, Housekeeping Supervisor and Maintenance Supervisor.</p> <p>5. 10/21/13</p>		

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F 329	Continued From page 9 was no evidence on the MAR that the dose of the medication, Zolofl, had been reduced as recommended by the pharmacist and approved by the physician. An interview with the Unit Manager conducted on 09/25/13 at 2:10 PM revealed the Unit Manager was responsible to ensure the pharmacy reviews were addressed after the physician had signed the review and agreed with the recommendation. The Unit Manager stated it was her responsibility to transcribe the pharmacist's recommendation, after it had been approved by the physician, to the resident's medical record as a physician's order. However, the Unit Manager stated she had "missed where the physician had agreed with the recommendation" for the decrease in the dosage of Zolofl for Resident #8.	F 329			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-DANVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
(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	<p>INITIAL COMMENTS</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1961, 1982, 1997</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: 7</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 09/24/13, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	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.