

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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 000	INITIAL COMMENTS An abbreviated survey was conducted on 03/11/13 through 03/13/13 for KY19880. The Division of Health Care substantiated the allegation with regulatory violations identified at 42 CFR 483.10 Resident Rights F157, 42 CFR 483.20 Resident Assessment F280, and 42 CFR 483.25 Quality of Care F309 at a scope and severity of a "G". The facility's noncompliance resulted in actual harm to one resident with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (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	F 157	F - 157: Notification of Change 1. As stated resident # 1 was transferred to the hospital on 4-25-12. No other resident was identified to be affected by the sited deficiency. 2. All residents will be assessed and records reviewed by Director of Nursing, MDS Nurse, Staff Development Nurse and Licensed Nurses by 4-8-13 to assure any significant change in resident's status or need to alter treatment is identified and resident, family and physician are notified timely. Resident records were also reviewed to assure current address and phone number of resident's legal representative/family member and resident notification prior to changes in room or roommate assignment by Social Service and Adminssion by 4-12-13.		

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

[Handwritten Signature]

TITLE

X Administrator

(X6) DATE

X 4-5-13

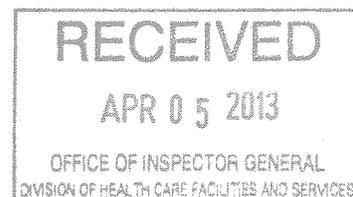
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
APR 5 2013
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

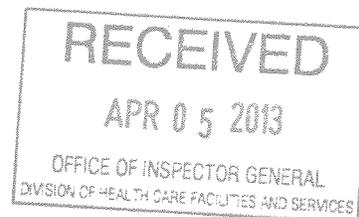
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 157	<p>Continued From page 1</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>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 notify the Primary Physician for one (1) of six (6) sampled residents (Resident #1) after a change in the resident's behaviors and a change in medical condition. Beginning on 03/02/12, Resident #1 displayed an increase in behaviors, which escalated on 03/11/12 with behaviors such as yelling, cursing and refusal of care. In addition, the resident exhibited a change in mental status of yelling, easily agitated and oriented to self only per the Psychiatrist on 03/15/12. From 03/02/12 until 03/11/12 the facility failed to notify the resident's primary physician and no change in treatment was obtained except for an increase in psychotropic medications by the Psychiatrist on 03/15/13, The resident continued to exhibit a change in condition on 03/18/12, by pulling at private parts, tearing incontinent briefs off and told staff his/her private area was burning. The resident continued with complaints of pain and behaviors without physician notification until 04/25/12 when the resident became lethargic, unable to open his/her eyes, and had an elevated temperature. The</p>	F 157	<p>Discrepancies identified during reviews will be corrected immediately.</p> <p>3. All policies and procedures for Notification of Significant Changes were reviewed and revised as indicated by Administrator, DON and RN Consultant on 3-20-13. DON & Staff Development Nurse inserviced licensed nurses and CNAs on policies and procedures on 4-8-13. All newly hired staff will be oriented to the facility policies during their new employee orientation. All licensed nurses were in-serviced on 24-hour report process on 3-18-13 by the DON and Staff Development Nurse and pain assessment and intervention by Dr. Pat Murphy on 3-29-13. Charge Nurses and CNAs will observe residents for status changes during routine unit rounds and care delivery. Any change identified will be reported, documented in the medical records and physician and family will be notified and included in the 24-hour report process.</p>		



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

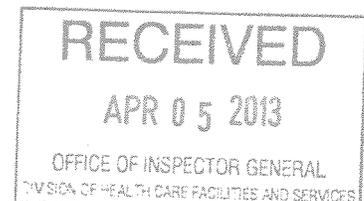
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 157	<p>Continued From page 2</p> <p>resident was transferred to the hospital with findings of Urosepsis. The facility's failure to notify the physician of the changes in behaviors, increased pain and complaints of burning resulted in the resident's admission to the hospital for treatment of Urosepsis with resident expiring in hospital during stay. Refer to F280 and F309</p> <p>The findings include:</p> <p>Review of the facility's Policy and Procedure for Notification of Physician, dated 11/08, revealed this facility would notify the attending physician of any pertinent information or any change in a resident's physical, mental or psychosocial status. Such changes may include but were not limited to the deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 05/26/11, with diagnoses of Alzheimer's Disease, Dementia with Behavior Disturbance, Coronary Artery Disease (CAD), Hypertension and Asthma. Review of the Admission Minimum Data Set (MDS), dated 06/08/11, and the Significant Change MDS, dated 09/10/11, revealed the facility assessed the resident with no behavioral symptoms. Review of the 02/14/12 Quarterly MDS revealed the facility assessed Resident #1 as not interviewable along with behavioral symptoms not directed toward others.</p> <p>Review of the Nurse's Notes, dated 03/02/12 through 03/11/12, revealed the resident was very vocal stating his/her private area was burning and</p>	F 157	<p>4. Unit Managers/Charge Nurses will review 100% of residents identified with status/altered treatment change per the 24-hour report to assure compliance. Residents identified will be reviewed in daily (Monday-Friday) clinical meetings with Administrator and DON. The DON/SDN will conduct a random 10% chart audit weekly to determine compliance with notification policy. The Administrator will review all audits, and findings will be reviewed in weekly/monthly QA to assure continued compliance.</p> <p>5. Completion Date: 4-12-13</p>	<p>4-12-13 4-13-13 <i>for Helen Deane</i> Ry PB 4-8-13</p>	



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 157	<p>Continued From page 3</p> <p>needing care. There was no evidence that any pain assessment or vital signs were obtained and no evidence the attending physician was notified. On 03/15/12, the facility had the resident's behaviors assessed by a Psychiatrist and he prescribed Depakote 250 milligrams (mg) three times a day with an assessment that identified the resident was "yelling today as a result of not being able to get to the bathroom, yet he/she was just taken shortly before the yelling started". The responsible party was notified on 03/16/12 of the increase in Depakote and reported behaviors of agitation, verbal abuse, tearful episodes, repetitive yelling out, and being socially inappropriate.</p> <p>Further review of the Nurse's Notes on 03/18, 03/20, 03/21, and 03/24/12 revealed the resident had increased complaints, exhibiting behaviors of tearing off the brief, restlessness, cursing at staff and other residents and pain. However, there was no evidence the facility completed a pain assessment or obtained vital signs to assess the resident's condition and there was no evidence the facility notified the attending physician. The facility obtained a verbal order on 03/31/12 from the Psychiatrist which increased the resident's Depakote medication from 250 mg three times a day to 500 mg twice a day.</p> <p>Continued review of the nurse's notes revealed on 04/21, 04/22, and 04/24/12 the resident's same behaviors continued and then he/she became lethargic. There was no evidence the facility notified the attending physician regarding the resident's condition. The resident's vital signs were not taken through out this time frame until 04/25/12 when he/she became lethargic and</p>	F 157			



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

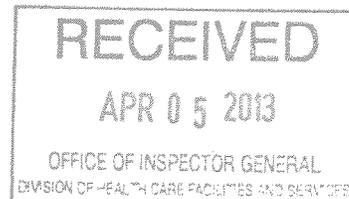
PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056
--	---

(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
--------------------	--	---------------	---	----------------------

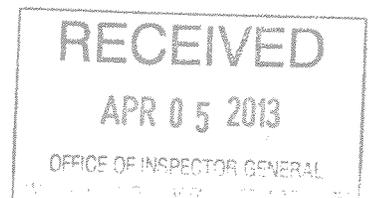
F 157	<p>Continued From page 4</p> <p>developed a fever of 100.1 axillary. The nurse's notes revealed the resident's attending physician was not notified until 04/25/12 when the resident was transferred to the hospital.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 03/13/13 at 12:30 PM, revealed she remembered caring for the resident and he/she was mostly pleasant; but at times would refuse care. She further stated the resident was easily redirected by talking about sports. She stated she had been trained to notify the nurse if a resident's behavior increased or changed so the nurse could document.</p> <p>Interview with CNA #3, on 03/13/13 at 12:45 PM, revealed she faintly remembered the resident and the behaviors, but could not remember them specifically. She could not remember anything about complaints of pain. However, any changes in the resident's condition should be reported to the nurse and she could not remember if she had reported anything to the nurses.</p> <p>Interview with License Practical Nurse (LPN) #3, on 03/13/13 at 12:50 PM, revealed the resident was mostly pleasant, but could be cantankerous about not wanting to get up and yelling out at times. However, she stated the resident could be easily redirected. LPN #3 reviewed the nurse's notes from 03/26/12 until 04/25/12 and stated there was a change in the resident's condition that should have been reported to the physician.</p> <p>Interview with LPN #2, on 03/13/13 at 1:20 PM, revealed she remembered caring for and being involved in the resident's transfer to the hospital on 04/25/12. She further stated prior to March</p>	F 157		
-------	--	-------	--	--



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 157	Continued From page 5 2012 the resident was alert but confused at times, and was pleasant but at times would get combative such as cursing and swing or kicking his/her feet. She continued to state the resident started to have increased confusion and was no longer able to be redirected. She stated the reason for notifying the Psychiatrist was because of the resident's increased behaviors. She continued to state the attending physician was not notified until the resident was lethargic. Interview with the Director of Nursing, on 03/13/13 at 2:45 PM, revealed the facility had assessed the resident to need a psychological consult and now realized no medical interventions were provided for the resident. She further stated the physician should have been notified when the resident displayed a change in condition on 03/02/13 when the resident first verbalized burning of his/her private area. Phone interview with the Primary Physician, on 03/13/13 at 11:40 PM, revealed the facility should notify him with all changes in a resident's condition. He indicated if he had been made aware of the resident's increase in pain, pulling at the brief, or change in mental status, perhaps labs and other treatment based on the lab results would have been ordered.	F 157			
F 280 SS=G	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.	F 280	1. As stated resident # 1 was transferred to the hospital on 4-25-12. No other residents were identified to be affected by the sited deficiency.		



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

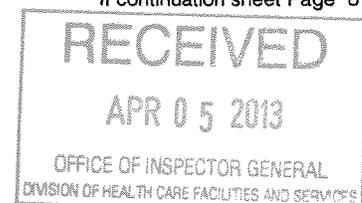
PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 280	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to revise the current care plan to address new behaviors, increased pain and complaints of burning in the genital area for one (1) of six (6) sampled residents, (Resident #1). On 03/02/12, Resident #1 had increased pain, behaviors, and a mental status change. The resident was observed by staff to be tearing off his/her brief, and was touching self in the private area. The resident's behaviors escalated during the month of March with an increase in Depakote and the addition of Seroquel for severe agitation, as well as an increase in the frequency of pain medication administration. On 04/25/12, the resident was found to be lethargic, unable to open his/her eyes, and was mumbling. The resident was transferred to the hospital with</p>	F 280	<p>2. All residents' Comprehensive Care Plans will be reviewed/revise by the Director of Nursing, MDS Nurse, Staff Development Nurse, and Licensed Nurse by 4-5-13 to assure accuracy and reflect resident current status needs. All care records will be updated to include individual resident care information.</p> <p>3. An in-service was held for the DON, MDS Nurses and Staff Development nurse on 4-4-13 by RN Nurse Consultant to review the federal guidelines for the RAI process, which includes the development and updating of the Comprehensive Care Plan. The DON, MDS Nurses and SDN reviewed the RAI process and facility policy with the other members of the interdisciplinary care team by 4-12-13.</p> <p>4. The interdisciplinary care team will review all assessments and care plans weekly during care conference of those residents scheduled to assure accuracy. All will be revised as indicated and documented. Unit Managers/Charge Nurses and MDS Nurses will monitor and update comprehensive care plans and all care records daily as indicated with change in residents' condition and orders.</p>		

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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

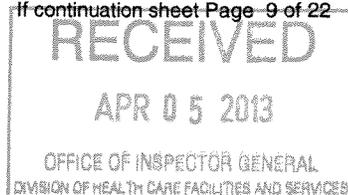
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 280	Continued From page 7 medical findings of Urosepsis. The facility's failure to revise the plan of care to address the resident's change in physical and psychosocial status resulted in an increase in behaviors, pain and a mental status change, and consequently required transfer to the hospital which resulted in actual harm for Resident #1. Refer to F157 and F309 The findings include: Interview with the Minimum Data Set (MDS) Coordinator, on 03/13/13 at 2:00 PM, revealed the facility did not have a policy regarding care plans; however, the facility utilized the CMS required MDS 3.0 manual. Review of the MDS 3.0 Manual, Chapter 4, Section 4-6, page 4-8, revealed facilities were responsible for assessing and addressing all care issues that were relevant to individual residents, regardless of whether or not they were covered by the Resident Assessment Instrument (RAI) (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions. Section 4-7, page 4-8, revealed the care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 05/26/11 with diagnoses of Hypertension, Alzheimer's Disease, Depression and Dementia with Behavioral Disturbance. Review of the Quarterly Minimum Data Set (MDS) for Resident	F 280	The DON and SDN will conduct weekly audits of scheduled assessments to assure accuracy in the Comprehensive Care Plan. Discrepancies will be corrected immediately. All audit results will be reviewed by administrator and presented in weekly/Monthly QA. 5. Completion date: 4-12-13	4-12-13 <i>4-13-13</i> <i>per Helen Burns</i> <i>by PB 4/13</i>	



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

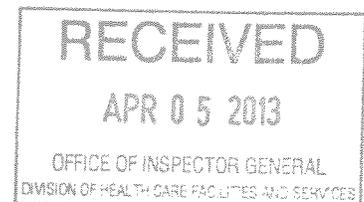
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 280	<p>Continued From page 8</p> <p>#1, dated 02/14/12, revealed the facility determined there were no behaviors of inattention, disorganized thinking, altered level of consciousness, or psychomotor retardation present. Continued review of the MDS revealed no physical or verbal behaviors had been exhibited. However, the MDS revealed the resident did have behavioral symptoms not directed toward others. Continued review of the MDS Pain Assessment revealed the resident had no pain; however, had the potential for pain related to repair of a fractured hip.</p> <p>Review of the Nurse's Notes, beginning 03/02/12 through 03/07/12 revealed the resident was restless and complaining of pain. On 03/11/12, the resident stated he/she was hurting in the private area. The resident stated he/she was sore all over on 03/12/12. There was no evidence the facility notified the attending physician of the resident's condition and no evidence of any pain assessment or vital signs obtained to assess the resident. However, review of the physician orders revealed the Psychiatrist visited and increased the resident's Depakote from 125 mg three times a day to 250 milligrams (mg) three times a day on 03/15/12. There was no evidence the plan of care was revised to address the change in the resident's condition.</p> <p>Continued review of the Nurses Notes revealed the resident tore his/her brief off on 03/18/12 and on 03/20/12, the resident was moaning in pain. On 03/21/12, the resident was medicated for continued pain and agitation. There was no evidence of a pain assessment completed by the facility. The resident displayed a change in behaviors manifested by cursing, agitation, and</p>	F 280			



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 280	<p>Continued From page 9</p> <p>not able to be redirected on 03/21/12 and there was no evidence the attending physician was notified of any of these changes. On 03/24/12, the resident was restless with facial grimaces and unable to be redirected and there was no evidence the attending physician was notified. However, review of the physician orders revealed on 03/29/12 the Psychiatrist increased the Depakote from 250 mg three times a day to 500 mg twice a day. There was no evidence the care plan was revised at this time to address the continued changes in the resident's condition.</p> <p>Continued review of the Nurses Notes revealed on 04/02/12, revealed the resident was restless and verbally abusive towards the staff. The resident was restless, loud and unable to sleep and was interfering in the other resident's ability to sleep on 04/07/12 and on 04/08/12, the resident was loud and growling. The resident was talking loudly, making facial grimaces, and disturbing the roommate on 04/12/12 and 04/14/12. There was no evidence in the clinical record that the attending physician was notified of the resident's condition. On 04/21/12, 04/22/12, and 04/24/12 the resident began yelling, cursing and complaining of back pain until the resident became lethargic. Again there was no evidence the attending physician was notified of the resident's condition and there was no evidence any pain assessments or vital signs obtained to assess the resident's condition. There was no evidence the care plan was revised at this time to address the escalation of symptoms displayed by the resident.</p> <p>The Nursing Notes further revealed on 04/25/12 at 6:15 AM, the resident's abdomen was</p>	F 280			



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

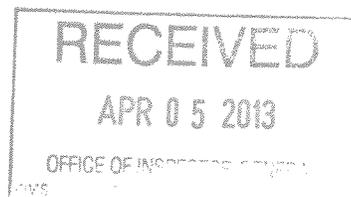
PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2013
--	---	--	--

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056
--	---

(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
--------------------	--	---------------	---	----------------------

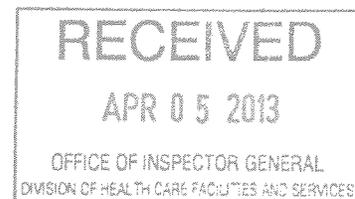
F 280	<p>Continued From page 10</p> <p>extended and hard to the touch. At 7:59 AM, the resident was lethargic, unable to open his/her eyes and vital signs at this time were blood pressure 122/83, pulse 120, respirations 18 and temperature was 99.7 axillary. At 11:30 AM, the resident was sleeping soundly, unable to open his/her eyes and vital signs were blood pressure 124/82, pulse 120, respirations 20, and temperature remained 99.7 axillary. At 3:30 PM the resident's temperature was 100.1 axillary. The 04/25/12 nurse's note revealed the resident was transferred to the hospital.</p> <p>Review of Resident #1's Pain Care Plan, revised 02/22/12, revealed the resident had occasional pain related to a hip fracture repair and denied pain during this assessment period. Interventions consisted of providing medication as ordered, assess for nonverbal signs of pain, modify activities, handle gently, and position for comfort. Review of the nurses notes for the month of March and April revealed the resident had new complaints of his/her private area burning, and increased complaints of back pain. Review of the Medication Administration Record (MAR) revealed starting on 03/02/12 the facility increased the frequency of the resident's pain medication. However, review of the Pain Care Plan revealed no evidence the care plan was revised to reflect the resident's symptoms of pain.</p> <p>Review of Resident #1's Behavioral Care Plan, revised 02/22/12, revealed the resident was agitated at meal times and easily redirected, and the approaches were to keep the resident's medications as minimal as possible; have MD review medications as needed; and to notify the physician of changes in eating, sleeping and task</p>	F 280		
-------	--	-------	--	--



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

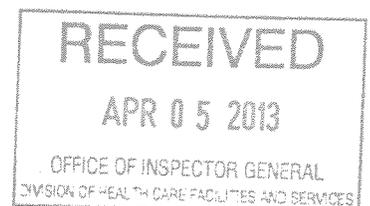
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 280	<p>Continued From page 11</p> <p>performance. However, on 03/15/12 and 03/29/12, the resident's psychotropic medication (Depakote) dosage was increased from 250 mg three times a day to 500 mg twice a day. In addition, on 03/29/12 an as needed (prn) antipsychotic medication Seroquel 25 mg was administered for severe agitation one time on 03/31/12. Continued review of the April 2012 MAR revealed the resident continued to be medicated as needed for severe agitation with no revisions to the care plan.</p> <p>Review of Resident #1's Urinary Care Plan, revised 02/22/12, revealed the resident experienced frequent bladder incontinence related to a decline in cognition and mobility. The goal was to have no skin breakdown. The interventions included: assist with toileting; check skin for breakdown; use briefs daily and check every 2 hours; take to the bathroom upon arising, before and after meals, before bedtime and as requested. These approaches did not reflect the resident's current documented complaints or concerns of burning of the private area to address any potential outcomes.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 03/13/13 at 12:30 PM, revealed she had often cared for Resident #1. She further stated the resident was pleasant and easily redirected with his/her behaviors. She stated the CNA plan of care was located in the computer system's care tracker, which provided a plan of care and interventions for residents. She continued to state CNAs were to notify the nurses immediately of any changes in a resident's condition.</p> <p>Interview with License Practical Nurse (LPN) #3,</p>	F 280			



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

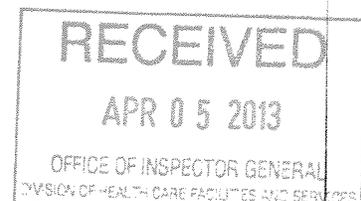
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 280	<p>Continued From page 12</p> <p>on 03/13/13 at 12:50 PM, revealed she remembered and cared for Resident #1. The LPN stated the resident was care planned and treated for behaviors. She further revealed nurses may add to the care plan; but the MDS team were responsible to update/revise the care plan. LPN #3 reviewed the nursing notes from 03/26/12 thru 04/25/12, and indicated the resident's care plan did not reflect the increase in pain, behavioral/mental status changes or the urinary complaints.</p> <p>Interview with LPN #2, on 03/13/13 at 1:20 PM, revealed she cared for the Resident #1 on the day he/she was admitted to the hospital. LPN #2 reviewed the resident's clinical record and she stated medical interventions should have been initiated and evaluated and the care plan should have been updated to reflect the resident's current status. LPN #2 stated the signs and symptoms of a UTI were fever, pain, burning upon urination and change in mental status. She continued to state "if you put all of the resident's complaints and behavioral symptoms together it may have triggered a medical problem".</p> <p>Interview with the MDS Coordinator, on 03/13/13 at 2:00 PM, revealed she was responsible for the accuracy of the care plan. She further indicated staff would notify her of a possible change in a resident's condition. Then she would assess the resident, review the clinical record and interview staff. She also stated the care plan team would assess for the root cause and frequency of the resident's problems and care plan accordingly. However, she stated the care plan team did not identify other causes of the resident's behavior such as medically related symptoms.</p>	F 280			



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 280	Continued From page 13	F 280			
F 309 SS=G	<p>Interview with the Director of Nursing, on 03/13/13 at 2:15 PM, revealed Resident #1 was evaluated by Psychological Services for behaviors. She stated it was a team effort in updating the care plan and the care plan should reflect the resident's current status. She further indicated, after reviewing Resident #1's nursing notes, that medical interventions such as vital signs and lab work to determine if the resident had a urinary tract infection, should have been reflected in the care plan, as well as the resident's complaints and symptoms.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>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 staff failed to identify the relationship between urinary symptoms, development of new behaviors and a change in mental status, failed to assess a resident utilizing vital signs and lab work and failed to seek treatment for one (1) of six (6) sampled residents, Resident #1. Beginning on</p>	F 309	<p>1. As stated resident #1 was transferred to the hospital on 4-25-12. No other residents were identified to be affected by sited deficiency.</p> <p>2. All resident medical records were reviewed by Director of Nursing, MDS Nurse, Staff Development Nurse and Licensed Nurses and completed on 4-5-13. The focus was on assessment for behavioral changes and pain to assure all care and services were being provided per physician's orders. Comprehensive care plans and CNA care records were updated as indicated to reflect resident's current status to assure accurate care and services in accordance with physician orders.</p>		



Attachment # 1

FRIENDSHIP MANOR NURSING HOME

**POLICY AND PROCEDURE
NURSING ASSESSMENTS**

Policy: It is the policy of Friendship Manor to establish and maintain a program to provide quality care through the comprehensive assessment of a resident's need and condition.

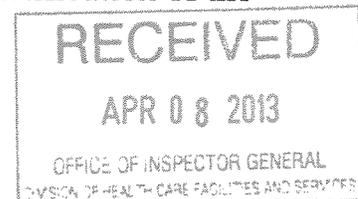
Procedures: The following assessments will be completed on any resident admitted to Friendship Manor at the time of admission:

- Minimum Data Assessment
- General comprehensive nursing assessment/Skin assessment
- Pain assessment
- Falls Assessment
- Bowel and Bladder Assessment
- Elopement Risk Assessment
- AIMS Assessment (for residents utilizing psychotropic medications)
- Physical Device Assessment
- Braden Scale (Upon admission and weekly for four weeks after admit

The following assessments will be completed quarterly or in the event of a significant change in accordance to the RAI process.

- Minimum Data Assessment
- Pain assessments
- Falls Assessments
- Bowel and Bladder Assessments
- Elopement Risk Assessments
- AIMS Assessment (for residents utilizing psychotropic medications)
- Physical Device Assessments
- Braden Scale Assessments

In the event of an acute / chronic change of condition the licensed nurse will complete a nursing assessment or the resident consisting of a clinical assessment including but limited to vital signs , physical and mental evaluation to assist in determining the cause of the change of condition The nurse will follow policies and procedures on notification of the



attending physician and resident's representative or family member.

RECEIVED

APR 08 2013

OFFICE OF INSPECTOR GENERAL

STATE OF NEW YORK DEPARTMENT OF HEALTH-CARE FACILITIES AND SERVICES

Apr 5 2013 06:01pm P003/007

Fax:

Attachment #1

FRIENDSHIP MANOR NURSING HOME

**POLICY AND PROCEDURE
NURSING ASSESSMENTS**

Policy: It is the policy of Friendship Manor to establish and maintain a program to provide quality care through the comprehensive assessment of a resident's need and condition.

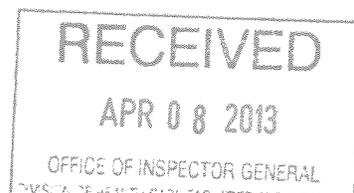
Procedures: The following assessments will be completed on any resident admitted to Friendship Manor at the time of admission:

- Minimum Data Assessment
- General comprehensive nursing assessment/Skin assessment
- Pain assessment
- Falls Assessment
- Bowel and Bladder Assessment
- Elopement Risk Assessment
- AIMS Assessment (for residents utilizing psychotropic medications)
- Physical Device Assessment
- Braden Scale (Upon admission and weekly for four weeks after admit

The following assessments will be completed quarterly or in the event of a significant change in accordance to the RAI process.

- Minimum Data Assessment
- Pain assessments
- Falls Assessments
- Bowel and Bladder Assessments
- Elopement Risk Assessments
- AIMS Assessment (for residents utilizing psychotropic medications)
- Physical Device Assessments
- Braden Scale Assessments

In the event of an acute / chronic change of condition the licensed nurse will complete a nursing assessment on the resident consisting of a clinical assessment including but limited to vital signs , physical and mental evaluation to assist in determining the cause of the change.. Nurses shall utilize the Care Path system to assist in following pathway of nursing



standard of practice. The assigned nurse shall follow policies and procedures as outlined for notification of attending physician and resident representative and of family member. The nurse will communicate the change of condition to the on-coming nurse for the subsequent shift and document the change on the twenty-four hour report record. Charge nurses are responsible to review the 24/hour report each shift and conduct appropriate follow up.

revised 04/2013

RECEIVED

APR 08 2013

OFFICE OF INSPECTOR GENERAL

DIVISION OF HEALTH CARE FACILITIES AND SERVICES

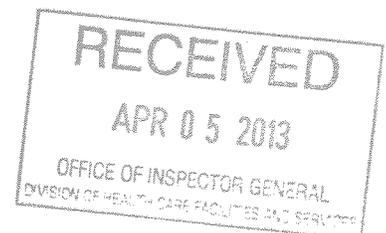
Apr 5 2013 06:01pm P005/007

Fax:

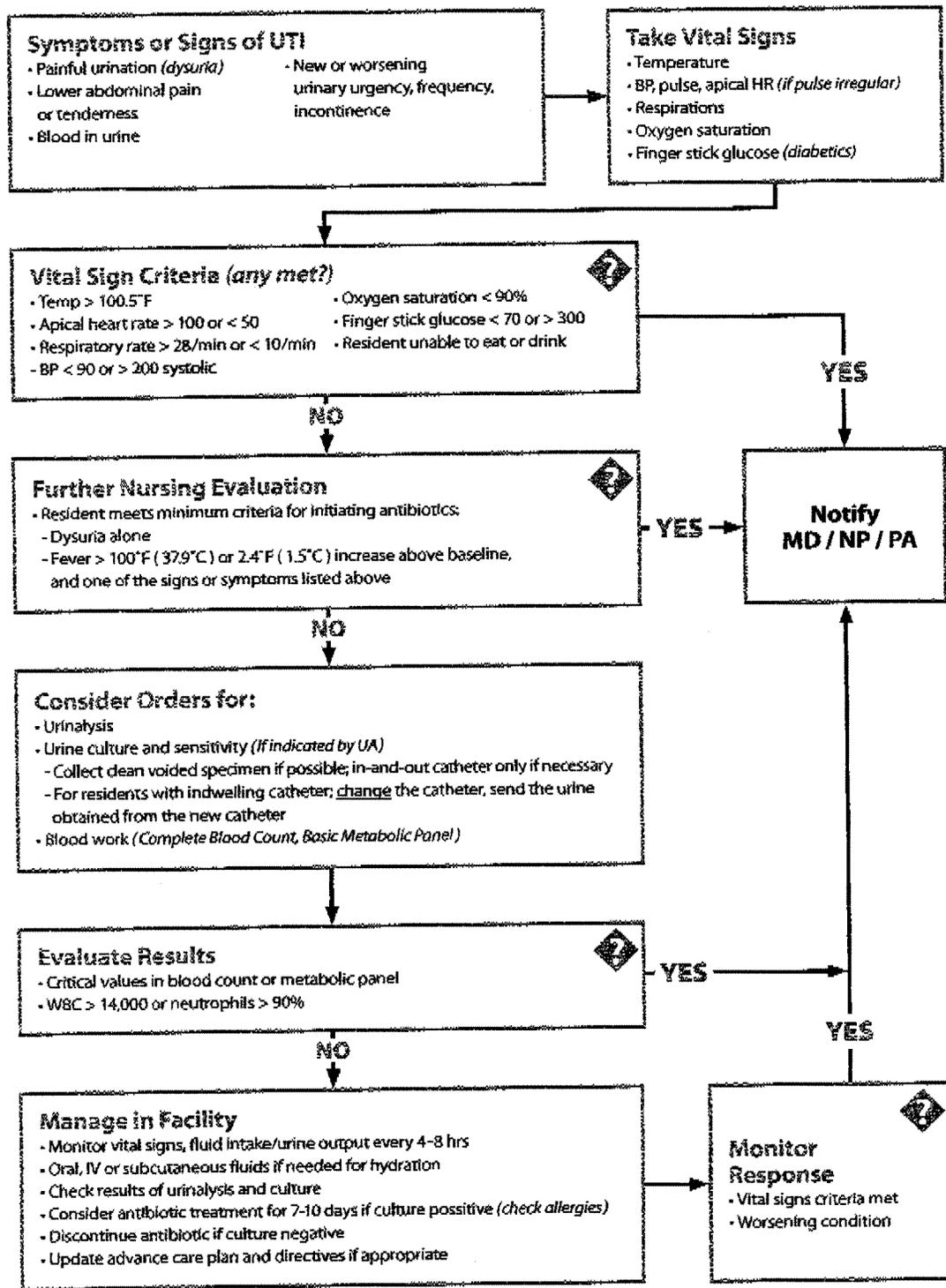
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 309	Continued From page 14 03/02/12, Resident #1 displayed an increase in behaviors that began to escalate on 03/11/12 with behaviors such as yelling, cursing and refusal of care. There was no evidence the Primary Physician was notified of these changes. The resident continued to exhibit a change in condition on 03/18/12, by pulling at private parts, tearing incontinent briefs off and telling staff his/her private area was burning. In addition, the resident exhibited a change in mental status of yelling, easily agitated and oriented to self only per the Psychiatrist on 03/15/12. The facility staff failed to assess the resident medically through vital signs and/or labs. From 03/02/12 until 04/25/12 the facility failed to notify the resident's primary physician and no change in treatment was obtained except for an increase in psychotropic medications by the Psychiatrist on 03/15/13 and 03/31/13 for behaviors. The resident continued with complaints of pain and behaviors without physician notification until 04/25/12 when the resident became lethargic, unable to open his/her eyes, and developed a temperature that continued to elevate. The resident was transferred to the hospital for evaluation on 04/25/12. The facility's failure to recognize and assess the resident's change in physical and psychosocial changes (increase in behaviors, pain and mental status change) resulted in the the resident's admission to the hospital for treatment of Urosepsis with the resident expiring in hospital during stay. Refer to F157 and F280 The findings include: Review of the facility's policy titled, Diagnosis and	F 309	3. The Policy and procedures regarding nursing assessments was revised to include the requirement of nurses to assess residents when they exhibit a change in condition. (attachment #1) The update was reviewed and approved by the DON, Medical Director and Administrator. The systemic change was to introduce the Interact Program that includes assessment tools and care paths that assist the nurses with actions to take and physician notification when an acute episode is identified. (sample attachment #2) The "Stop and Watch" tool was also introduced to assist the CNA's to be alert to condition changes in residents. (attachment #3) The 24/hr report process was revised so that nurses are required to sign when receiving report. When a change is identified, the licensed nurse will the assess the resident, provide emergency treatment if necessary, and notify the physician and family. The nurse will use the tools in the Interact Program as a reference if needed.		



CARE PATH Symptoms of Urinary Tract Infection (UTI)



RECEIVED
APR 8 2013
OFFICE OF INSPECTOR GENERAL
VISION OF HEALTH CARE FACILITIES AND SERVICES

Stop and Watch Early Warning Tool



If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

- | | |
|----------|--|
| S | Seems different than usual |
| T | Talks or communicates less |
| O | Overall needs more help |
| P | Pain – new or worsening; Participated less in activities |
| a | Ate less |
| n | No bowel movement in 3 days; or diarrhea |
| d | Drank less |
| W | Weight change |
| A | Agitated or nervous more than usual |
| T | Tired, weak, confused, or drowsy |
| C | Change in skin color or condition |
| H | Help with walking, transferring, toileting more than usual |

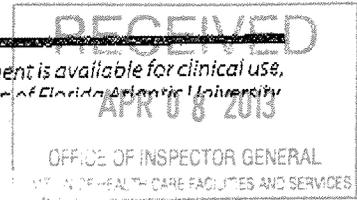
Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name



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

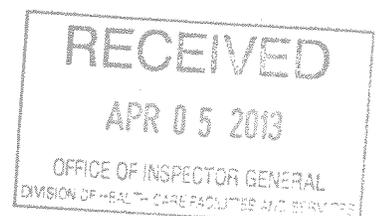
PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056
--	---

(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
--------------------	--	---------------	---	----------------------

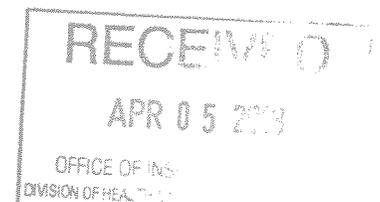
F 309	<p>Continued From page 15</p> <p>Treatment of Urinary Tract Infections, (UTI), undated, revealed guidelines to diagnose and treat urinary tract infections. The policy stated the the facility would test and treat a urinary tract infection based on three (3) of the five (5) signs and symptoms. 1. Fever, indicated by greater than two (2) degrees or a single temperature of greater than 100 degrees. 2. New or increased burning pain on urination, frequency or urgency. 3. New flank or suprapubic pain or tenderness. 4. Change in character of urine as reported by the laboratory. 5. Worsening of mental or functional status.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 05/26/11 with diagnoses of Hypertension, Alzheimer's Disease, Depression and Dementia with Behavioral Disturbance. Review of the Admission Minimum Data Set (MDS), dated 06/08/11, and the Significant Change MDS, dated 09/10/11, revealed the facility assessed the resident with no behavioral symptoms. Review of the Quarterly MDS for Resident #1, dated 02/14/12, revealed no behaviors of inattention, disorganized thinking, altered level of consciousness, or psychomotor retardation were present. Continued review of the MDS revealed no physical or verbal behaviors were exhibited. However, the MDS revealed the resident did have behavioral symptoms not directed toward others, in addition, the facility assessed the resident as incontinent of bowel and bladder related to cognition and mobility. Continued review of the MDS Pain Assessment revealed the resident had no pain; however, had the potential for pain related to the repair of a fractured hip.</p>	F 309	<p>Treatment will be provided in accordance with the physician's orders. Information will be communicated during shift report and documented on the 24/hr report.</p> <p>The care plan will be updated accordingly.</p> <p>Licensed nurses were inserviced on the systemic changes on 3/18 and 3/19/13 by the DON and SDN.</p> <p>The DON and SDN conducted education 3/18, 3/29 and 4/4/13 on providing care and services in accordance with each resident according to the comprehensive care plan which is review and revised with change in status.</p> <p>Licensed nurses completed a post-test to validate their knowledge of the content of the inservices.</p> <p>4.The Unit Managers/Charge Nurses will review each resident on the 24/hr report to ensure proper follow-up related to assessment and notification. The medical records of residents who</p>	
-------	---	-------	---	--



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

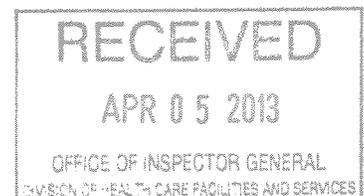
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 309	<p>Continued From page 16</p> <p>Review of the Nurse's Notes, beginning 03/02/12 through 03/07/12 revealed the resident was restless and complaining of pain. Review of the March 2012 MAR revealed the resident received as needed Lortab 5-500 tabs for complaints of pain on 03/02, 03/06, 03/07 and twice on 03/10/12. On 03/11/12, the resident stated he/she was hurting in the private area. The resident stated he/she was sore all over on 03/12/12. There was no evidence the facility notified the attending physician of the resident's condition and no evidence that any pain assessment or vital signs were obtained to assess the resident. However, on 03/15/12, the facility had the resident's behaviors assessed by a Psychiatrist and he prescribed an increase in Depakote from 125 milligrams (mg) three times a day to 250 mg three times a day with an assessment that identified the resident as "yelling today as a result of not being able to get to the bathroom, yet he/she was just taken shortly before the yelling started". The responsible party was notified on 03/16/12 of the increase in Depakote and reported behaviors of agitation, verbally abusive, tearful episodes, repetitive yelling out, and being socially inappropriate. Review of the March 2012 MAR revealed the resident received as needed Lortab 5-500 tabs on 03/16/12.</p> <p>Continued review of the Nurses Notes revealed the resident tore his/her brief off on 03/18/12 and on 03/20/12, the resident was moaning in pain. The March 2012 MAR revealed the resident was administered Lortab for pain on 03/20/12. On 03/21/12, the resident was medicated for continued pain with Lortab as needed and Depakote for the agitation. The resident displayed a change in behaviors manifested by cursing,</p>	F 309	<p>experienced acute episodes will be reviewed at the daily clinical meeting that includes the DON and Administrator. (Residents who experienced condition change over the weekend will be discussed at the Monday morning clinical meeting). The Unit Managers will communicate information from the record to show that medically related assessments for residents with an acute episodes are completed timely with proper notification and follow-up according to physician's orders.</p> <p>The Director of Nursing or Staff Development Nurse will conduct a random 10% chart audit weekly of residents identified to determine compliance. The DON will review results of the monitoring and present to the QA committee.</p> <p>5. Completion Date: 4-12-13</p>	4-12-13	



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

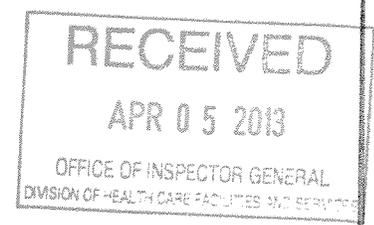
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056	
(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 309	<p>Continued From page 17</p> <p>agitation, and not able to be redirected on 03/21/12 and there was no evidence a pain assessment was completed to assess the resident's condition or that the attending physician was notified of any of these changes. On 03/24/12, the resident was restless with facial grimaces and unable to be redirected and the March 2012 MAR indicated the resident received Lortab on 03/25, 03/26, and 03/37/12 for pain. There was no evidence a pain assessment was completed at this time or that the attending physician was notified of the resident's condition. However, review of the physician orders revealed on 03/29/12 the Psychiatrist increased the Depakote from 250 mg three times a day to 500 mg twice a day.</p> <p>Further review of the Nurses Notes revealed on 04/02/12, the resident was restless and verbally abusive towards the staff. Review of the April 2012 MAR revealed the resident received Seroquel 25 mg for severe agitation on 04/05/12. The resident was restless, loud and unable to sleep and was interfering in the other resident's ability to sleep on 04/07/12 and the April 2012 MAR indicated the resident was administered Lortab for pain. On 04/08/12, the resident was loud and growling. The resident was talking loudly, making facial grimaces, and disturbing the roommate on 04/12/12 and 04/14/12. However, review of the April 2012 MAR revealed the resident received pain medication only on 04/12/12. The April 2012 MAR indicated the resident was administered Seroquel 25 mg for severe agitation on 04/16/12. There was no evidence in the clinical record a pain assessment was ever completed or that the attending physician was notified of the resident's condition.</p>	F 309		



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

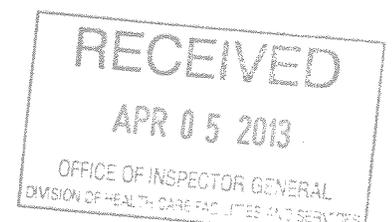
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 309	<p>Continued From page 18</p> <p>On 04/21/12, 04/22/12, and 04/24/12 the resident began yelling, cursing and complaining of back pain until the resident became lethargic. There was no evidence the resident received Lortab or Seroquel since 04/16/12 nor was there any evidence the attending physician was notified of the resident's condition or any evidence that a pain assessment or vital signs were obtained to assess the resident's condition.</p> <p>Additional review of the Nursing Notes revealed on 04/25/12 at 6:15 AM, the resident's abdomen was extended and hard to the touch. At 7:59 AM, the resident was lethargic, unable to open his/her eyes and vital signs at this time were blood pressure 122/83, pulse 120, respirations 18 and temperature was 99.7 axillary. At 11:30 AM, the resident was sleeping soundly, unable to open his/her eyes and vital signs were blood pressure 124/82, pulse 120, respirations 20, and temperature remained 99.7 axillary. At 3:30 PM the resident's temperature elevated to 100.1 axillary. The 04/25/12 Nurse's Note stated the resident was transferred to the hospital.</p> <p>Review of Resident #1's Pain Care Plan, revised 02/22/12, revealed the resident had occasional pain related to a hip fracture repair and denied pain during this assessment period. Interventions consisted of providing medication as ordered, assess for nonverbal signs of pain, modify activities, handle gently, and position for comfort. Review of the Nurses Notes for the month of March and April revealed the resident had new complaints of his/her private area burning, and increased complaints of back pain. Review of the Medication Administration Record (MAR) revealed starting on 03/02/12 the facility</p>	F 309			



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

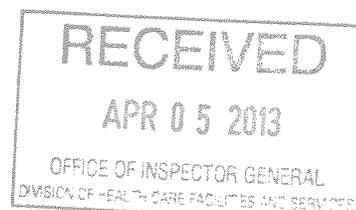
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 309	<p>Continued From page 19</p> <p>increased the frequency of the resident's pain medication Lortab.</p> <p>Review of Resident #1's Behavioral Care Plan, revised 02/22/12, revealed the resident was agitated at meal times and easily redirected, and the approaches were to keep the resident's medications as minimal as possible; have MD review medications as needed; and to notify the physician of changes in eating, sleeping and task performance. However, on 03/15/12 and 03/29/12, the resident's psychotropic medication (Depakote) dosage was increased from 250 mg three times a day to 500 mg twice a day. In addition, on 03/29/12 an as needed (prn) antipsychotic medication Seroquel 25 mg was administered for severe agitation one time on 03/31/12. Continued review of the April 2012 MAR revealed the resident continued to be medicated as needed for symptoms of severe agitation on four occasions.</p> <p>Review of Resident #1's Urinary Care Plan, revised 02/22/12, revealed the resident experienced frequent bladder incontinence related to a decline in cognition and mobility. The goal was to have no skin breakdown. The interventions included: assist with toileting; check skin for breakdown; use briefs daily and check every 2 hours; and take to the bathroom upon arising, before and after meals, before bedtime and as requested. These approaches did not reflect the resident's current documented complaints or concerns of burning of the private area to address any potential outcomes.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 03/13/13 at 12:30 PM, revealed she had</p>	F 309			



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 309	<p>Continued From page 20</p> <p>cared for Resident #1 often. She further stated the resident was pleasant and easily redirected for his/her behaviors. She continued to state CNAs were to notify the nurses of any changes in a resident's condition and the nurses were responsible to document and follow up on the changes.</p> <p>Interview with CNA #3, on 03/13/13 at 12:45 PM, revealed she faintly remembered the resident and the behaviors, but could not remember them specifically. She could not remember anything about complaints of pain. However, any changes in the resident's condition should be reported to the nurse and she could not remember if she had reported anything to the nurses.</p> <p>Interview with License Practical Nurse (LPN) #3, on 03/13/13 at 12:50 PM, revealed she remembered and cared for the Resident #1. LPN #3 stated the primary physician should be notified of any changes in a resident's condition. LPN #3 reviewed the nursing notes from 03/26/12 thru 04/25/12, and she indicated this was not the resident's normal status and medical interventions such as vital signs and lab work should have been implemented.</p> <p>Interview with LPN #2, on 03/13/13 at 1:20 PM, revealed she cared for the Resident #1 on the day he/she was admitted to the hospital. LPN #2 reviewed the clinical record of the resident, and she stated medical interventions should have been initiated to evaluate the resident's condition. LPN #2 stated the signs and symptoms of a UTI are fever, pain, burning upon urination and change in mental status. She continued to state the resident's behaviors were treated; however,</p>	F 309			



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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2013
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(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 309	Continued From page 21 no medical interventions were initiated or assessed. Interview with the MDS Coordinator, on 03/13/13 at 2:00 PM, revealed the nursing staff had only identified a change in behaviors, and this initiated a change on the behavior care plan; however, the staff never reported to her anything about pain. Interview with the Director of Nursing, on 03/13/13 at 2:15 PM, revealed the resident was evaluated by Psychological Services for behaviors. She further indicated after reviewing Resident #1's Nursing Notes that medical interventions, such as vital signs and lab work should have been initiated when the resident complained of his/her privates burning, increase in pain and mental status changes. She further indicated more concern was placed on behavioral treatment and not medical treatment. Phone interview with the Primary Physician, on 03/13/13 at 11:40 PM, revealed he visited the facility weekly and the facility identify's residents that need to be assessed. He stated the facility should notify him with all changes in a resident's condition. The Physician continued to state he could not remember the details of Resident #1; but did remember the resident was being treated for behaviors. He indicated if he had been made aware of the resident's increase in pain, pulling at the brief, or change in mental status, perhaps labs and other treatment based on the lab results would have been ordered.	F 309			

