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

PRINTED: 09/04/201
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 08/21/2014
NAME OF PROVIDER OR SUPPLIER: DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	

(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	F 000	To the best of my knowledge and belief, as an agent of Diversicare of Nicholasville, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	
	An Abbreviated Survey investigating KY00022062 and KY00022107 was initiated on 08/18/14 and concluded on 08/21/14. KY00022062 was unsubstantiated with no deficiencies cited. KY00022107 was unsubstantiated with unrelated deficiencies cited.			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280	
	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.		The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.		The care plan of resident #1 was revised on 8/21/14 with a quarterly care plan update stating the resident was waiting to receive dentures. The dentures for resident #1 were paid for by the Administrator on 8/21/14 and resident #1's follow up appointment to pick up the dentures was on 8/25/14. On 8/25/14 resident #1 received the dentures at	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the Comprehensive Care Plan was			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: SAM FRAZIER | TITLE: ADMINISTRATOR | (X6) DATE: 9/12/14

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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revised related to a change of status for one (1) of four (4) sampled residents (Resident #1). Resident #1's Comprehensive Care Plan was not revised to reflect a change in status when his/her dentures dentures were broken and went missing.

The findings include:

No policy/guideline on care plans was provided after Surveyor request.

Interview with the Director of Nursing (DON), on 08/21/14 at 2:58 PM, revealed it was her expectation residents' Comprehensive Care Plans were to be updated when a change occurred in a resident's status.

Review of Resident #1's medical record revealed the facility initially admitted the resident on 03/26/14, and re-admitted him/her on 07/21/14, with diagnoses which included Hypertension, Congestive Heart Failure, Diabetes, Dysphagia (Difficulty Swallowing), and Hemiplegia (paralysis of one side of the body). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 05/22/14, revealed the facility assessed the resident to have moderate cognitive impairment. Review of the Comprehensive Care Plan revealed Resident #1 was care planned on 11/05/13 for being at risk for impaired swallowing with interventions which included staff assistance with cleaning and inserting dentures as necessary. Continued review of the care plan revealed Resident #1 was care planned on 04/08/13 for altered nutritional risk/risk for wt loss with interventions which included staff to observe for any signs or symptoms of difficulty chewing or swallowing, and to assist with oral care twice a

F 280 the appointment. Upon resident #1 returning to the facility with dentures resident #1's care plan was again updated to reflect that resident #1 has the new dentures.

On 8/22/14 an audit was conducted by the Director of Nursing (DON) and MDS Coordinator of all residents that have dentures to assure their care plans are consistent with those residents. No additional deficient practices were found at that time.

A new customer concern form was implemented 09/02/14 for residents, families and / or staff to complete with any type of concerns as a new communication tool. Dietary, Nursing, Administration and Housekeeping staff were educated on the concern form by the DON at the in-services on 8/27/14 and 9/03/14. Once completed the forms are collected on morning rounds prior to morning meeting where they are given to the Administrator for review. The Administrator reviews concerns on a daily basis Monday – Friday with the Interdisciplinary Team (IDT). Concerns from the weekend are reviewed on Mondays. The MDS coordinator makes notes to update the care plan as appropriate and timely. Electronic medical records

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F 280	Continued From page 2 day and as necessary. Interview with the Speech Language Pathologist (SLP) on 08/20/14 at 11:53 AM, and on 08/21/14 at 8:49 AM, revealed Resident #1 had dentures and wore them most of the time including when he/she ate. However, observation of Resident #1 on 08/19/14 at 10:40 AM, revealed the resident had no dentures in his/her mouth. Interview with Resident #1, at the time of the observation, revealed he/she had no dentures at this time. Resident #1 stated he/she had dentures; but, the dentures were broken about a month ago. Resident #1 stated he/she was supposed to get new dentures to replace the broken ones. Interview with Certified Nursing Assistant (CNA) #6 on 08/20/14 at 9:47 AM, revealed Resident #1 had used his/her dentures, prior to them being broken, including when he/she ate. CNA #6 stated Resident #1 was waiting to get a new set of dentures. The CNA further stated she thought the resident had been without dentures for approximately a month. Interview with Registered Nurse (RN) #1/House Supervisor (HS) on 08/21/14 at 10:00 AM, revealed on 07/21/14 or 07/22/14 an aide reported Resident #1's dentures were broken and then went missing. The RN #1/HS revealed the facility investigated; however, were unable to find Resident #1's broken dentures. However, further record review revealed no documented evidence the Comprehensive Care Plan was revised when Resident #1's dentures were broken and went missing.	F 280	system was implemented and rolled out in phases during the months of August and September that will also assist in updating care plans and reduce in communication breakdown as the residents' clinical information is consistent throughout the clinical record. In addition to the daily reviews, concerns and grievances will be continuously reviewed by the Quality Assurance Performance Improvement (QAPI) team at a monthly meeting. The MDS Coordinator is part of that team and will continue to update care plans accordingly. Risk Management nurse will electronically audit care plans in conjunction with the weekly care plan schedule to assure compliance. The QAPI team includes: Administrator, DON, MDS Coordinator, Staff Development Coordinator, Risk Manager, Social Services, Business Office Manager, Human Resources, Medical Records Clerk, Dietary Manager, Activity Director, Pharmacist and Medical Director. Date of Completion: 09/20/14	

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F 280	Continued From page 3	F 280		
	Interview with the MDS Coordinator on 08/21/14 at 4:05 PM, revealed the broken and lost dentures changed Resident #1's eating status; however, the Comprehensive Care Plans related to swallowing and nutrition were not updated to include this information. The MDS Coordinator revealed the care plans were not updated because she had not been made aware the resident's dentures were missing. The MDS Coordinator indicated had she been aware she would have updated the care plans to include this information. Further interview with the DON on 08/20/14 at 3:54 PM and on 08/21/14 at 2:58 PM, revealed Resident #1's dentures were broken and missing at the end of June, and this had a potential impact on the resident's Comprehensive Care Plan. The DON revealed the MDS Coordinator was not informed the dentures were broken and missing so the care plan was not revised and no interventions were put in place. The DON indicated the MDS Coordinator should have been made aware of the broken and missing dentures however, so the care plan could have been revised.			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to	F 367	F367 Therapeutic diets must be prescribed by the attending physician. Once realized resident #3 was receiving the incorrect diet resident #3 was monitored by the charge nurse for any side effects; none witnessed. Resident #3 requested	

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provide the therapeutic diet in accordance with the Physician's Orders for one (1) of four (4) sampled residents (Resident #3).

Review of Resident #3's Physician's Dietary Orders revealed the resident was to have a mechanical soft textured diet; however, observations and interview revealed the resident was served regular textured food.

The findings include:

Interview, on 08/21/14 at 4:17 PM, with the Administrator revealed his expectation was for staff to follow Physician Orders.

Review of Resident #3's medical record revealed the facility admitted the resident on 07/03/14, with diagnoses which included Gastroesophageal Reflux Disease (stomach acid up the esophagus), Hypertension, Macular Degeneration, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) Assessment dated 07/11/14, revealed the facility assessed Resident #3 to require a mechanically altered diet. Review of the August 2014 monthly Physician's Orders revealed an order for mechanical soft, no added salt diet.

Observation, on 08/19/14 at 11:54 AM, of the Resident #3's meal tray revealed the resident's food was regular in texture. Further observation revealed the resident's meal ticket noted Resident #3 was on a regular diet.

Observation of Resident #3's lunch meal on 08/20/14 at 11:41 AM revealed the resident' meal was regular in texture and the meal ticket continued to note he/she was on a regular diet.

F 367 to change his/her diet to a regular diet; physician's order to upgrade resident #3's diet was received on 08/20/14. The communication form dated 7/11/14 read mechanical soft diet from the nursing staff to the dietary staff. The Dietary Manager made a mistake when transferring the type of diet. That particular dietary manager is no longer in that position.

On 08/20/14 the DON and Dietary Manager completed an audit of all residents' dietary cards to assure accuracy on all residents' diets. No additional deficient practices were found at that time.

Education was provided by dietician on 08/22/14 to all dietary staff regarding therapeutic diets and the importance of accuracy. A new electronic tray card system was implemented on 09/02/14 as opposed to the handwritten system that was utilized when the error occurred. This will reduce transcription errors. In addition, a designee, assigned by the Administrator, will conduct weekly line audits to assure accuracy on all residents' trays.

Tray accuracy has been added to the Dietary Manager's monthly audits that will be reviewed by the

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F 367	Continued From page 5 Interview with RN #4, at the time of the observation revealed Resident #3's meal ticket showed the resident was on a regular diet and the food served was regular in texture. Interview with Certified Nurse Assistant (CNA) #2 on 08/21/14 at 11:54 AM, revealed when staff passed the meal trays they were to check the meal card (meal ticket) prior to serving the tray, to see what type of diet a resident was to be served and if it was the right diet. CNA #2 stated if the meal card noted a resident was on a regular texture staff made sure the meal food texture was regular. Interview with Dietary Aide (DA) #1 on 08/21/14 at 11:59 AM, revealed when serving food on the meal tray line dietary staff looked at the meal ticket to see what type of diet a resident was to be served. DA #1 stated if the meal ticket identified a regular diet, the resident was served regular textured food. Interview with the Dietician on 08/20/14 at 3:20 PM, revealed a diet communication card was sent to the kitchen and which showed what type of diet was ordered for a resident. The Dietician revealed the meal ticket was supposed to match the diet noted on the communication card, and dietary staff served the diet indicated on the resident's meal ticket. The Dietician further revealed Resident #3's mechanical soft diet was ordered by the Physician and was ordered if there were concerns about the resident's chewing and swallowing. Interview with the Dietary Manager (DM) on 08/20/14 at 3:08 PM, Resident #3's diet card (meal ticket) showed the resident was on a	F 367	Quality Assurance Performance Improvement (QAPI) team at a monthly meeting. This will be monitored for a minimum of three months or until 100% compliance is achieved. The registered dietician also does monthly accuracy audits as part of her quality assurance audit. The QAPI team includes: Administrator, DON, MDS Coordinator, Staff Development Coordinator, Risk Manager, Social Services, Business Office Manager, Human Resources, Medical Records Clerk, Dietary Manager, Activity Director, Pharmacist and Medical Director. Date of Completion: 09/20/14	

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F 367	Continued From page 6 regular diet. In an additional interview with the DM on 08/21/14 at 12:32 PM, he revealed Resident #3's diet communication card showed an order for the resident to have a mechanical soft texture. The DM stated Resident #3 should have been being served a mechanical soft diet, and not a regular texture diet. Interview with the Director of Nursing (DON) on 08/21/14 at 2:58 PM, revealed Resident #3 had a Physician's Order for a mechanical soft diet; however, the resident had been served a regular diet due to the meal tray card being marked incorrectly. She stated therefore, the resident had not received the diet and food texture ordered. The DON further stated there was the potential for nutritional risk for Resident #3 because the resident was not served the ordered diet.	F 367		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. On 8/21/14 Social Services Director documented on resident #1 regarding the care plan conference with the family that took place on 8/21/14, facility purchasing the dentures and scheduled appointment to receive dentures on 8/25/14.	

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This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, it was determined the facility failed to ensure the medical record was complete and accurately documented for one (1) of four (4) sampled residents (Resident #1).

Resident #1 dentures were broken and went missing; however, record review revealed no documented evidence of this information, or of notification of the resident's family or Power of Attorney (POA) or Physician. Additionally, record review revealed no documented evidence of denture replacement appointments having been scheduled.

The findings include:

The facility provided no policy/guidelines related to residents' medical record documentation. However, interview with the Administrator on 08/21/14 at 4:17 PM, revealed he expected residents' medical records to be documented completely and accurately.

Review of Resident #1's medical record revealed the facility admitted the resident on 03/26/14 and re-admitted him/her on 07/21/14, with diagnoses which included Hemiplegia (paralysis one side of the body), Diabetes and Dysphagia (Difficulty Swallowing). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/22/14, revealed the facility assessed Resident #1 to be moderately cognitively impaired; however, interviewable.

Interview with Resident #1 on 08/19/14 at 10:40

F 514

During the week 8/25 – 8/29/14 the Administrator and Social Services Director conducted an audit of the past three months' grievance logs to ensure follow up was documented. Additional concerns were immediately addressed.

Education was provided to the Social Services Director by the Administrator on what he expects to be documented in the clinical record during the week of 8/25 – 8/29/14. A new customer concern form was implemented 09/02/14 for residents, families and / or staff to complete with any type of concerns as a new communication tool. Dietary, Nursing, Administration and Housekeeping staff were educated on the concern form by the DON at the in-services on 8/27/14 and 9/03/14. Once completed the forms are collected on morning rounds prior to morning meeting where they are given to the Administrator for review. The Administrator reviews concerns on a daily basis Monday – Friday with the Interdisciplinary Team (IDT). Concerns from the weekend are reviewed on Mondays. During this review the Social Services Director makes notes to update the clinical record as appropriate and timely. Electronic medical records system

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F 514	Continued From page 8 AM, revealed he/she had dentures, but they were broken about a month ago. Resident #1 revealed the facility had sent him/her out to denture appointments, and he/she was supposed to get new dentures. The resident further revealed however, he/she was not aware of the status of the new dentures. Interview with Certified Nursing Assistant (CNA) #6 on 08/20/14 at 9:47 AM, revealed Resident #1's had been broken, and the resident was waiting to get a new set of dentures. CNA #6 reported she thought it had been approximately a month Resident #1 had been without dentures. Further review of Resident #1's medical record revealed no documented evidence regarding: the missing dentures; the facility's replacement plan for the dentures; notifications of the Physician or resident's family or POA in regards to the broken and missing dentures; or of denture appointments having been scheduled. Interview with Registered Nurse (RN)#1/House Supervisor (HS) on 08/21/14 at 10:00 AM, revealed a Certified Nursing Assistant (CNA) had reported Resident #1's dentures were broken and then went missing on 07/21/14 or 07/22/14, and the family was notified then of that information. However, RN #1/HS revealed the information regarding the broken and missing dentures, and family notification were not documented in the chart, but should have been. Interview with the Social Services Director (SSD) on 08/20/14 at 4:36 PM, revealed Resident #1's dentures were missing around 06/23/14, and this was investigated; but, she stated she had not documented the this information in the resident's	F 514	was implemented and rolled out in phases during the months of August and September that will assist staff with communication regarding the residents' notifications, appointments, etc. In addition to the daily reviews, concerns and grievances will be reviewed by the Quality Assurance Performance Improvement (QAPI) team at a monthly meeting. The Social Service Director is part of that team and will continue to update residents' records accurately and completely. Social service notes will be audited monthly for a minimum of three months by a designee, assigned by the Administrator, to assure compliance. The QAPI team includes: Administrator, DON, MDS Coordinator, Staff Development Coordinator, Risk Manager, Social Services, Business Office Manager, Human Resources, Medical Records Clerk, Dietary Manager, Activity Director, Pharmacist and Medical Director. Date of Completion: 09/20/14	

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	medical record. The SSD stated however, the missing dentures, and related denture replacement appointment information should have been documented in Resident #1's record. According to the SSD, she had not received guidance on what was supposed to be documented in residents' medical records.	F 514		
	Interview with the Director of Nursing (DON) on 08/20/14 at 3:54 PM and 08/21/14 at 2:58 PM, revealed residents' medical records were expected to be complete and accurate. The DON revealed nursing staff and the SSD should have documented Resident #1's broken and missing dentures. The DON further revealed when Resident #1's denture replacement follow-up and appointments should have been documented in the resident's record by the SSD.			