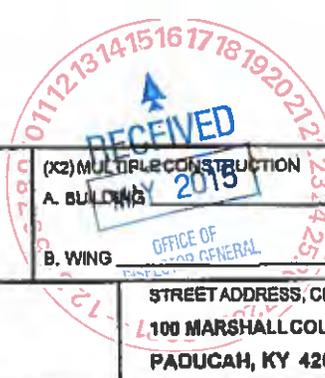


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/07/2015
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NAME OF PROVIDER OR SUPPLIER  SUPERIOR CAREHOME	STREET ADDRESS, CITY, STATE, ZIP CODE 100 MARSHALL COURT PADUCAH, KY 42001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000  F 157 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Survey investigating complaints #KY23029, KY23013 and KY23014 was conducted on 03/31/15 through 04/07/15. Complaint #KY23029 was substantiated with deficiencies cited with the highest Scope and Severity of a "D". KY23013 and KY23014 were unsubstantiated with no deficiencies identified.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 000  F 157	<p><b>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted</b></p> <ol style="list-style-type: none"> <li>The resident who was affected by the deficient practice is no longer a resident in this facility.</li> <li>On 4/14/2015, the DON reviewed 10% of all clinical records for proper family notification and found no further deficient practice.</li> <li>The facility will re-educate its licensed staff on family notification as it relates to a change in a resident's condition and/or new physician orders. The facility will also ensure that proper documentation is in place in the Nurses Notes for the notification of family and/or responsible parties.</li> </ol>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X5) DATE 5-15-15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</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 facility policy and complaint report, it was determined the facility failed to notify the family when there was a need to alter treatment for one (1) of six (6) sampled residents (Resident #1). On 03/13/15, Resident #1's urine was noted to have a foul order. A Urinalysis (UA) with Culture and Sensitivity (C&amp;S) was obtained and the physician ordered an antibiotic; however, there was no documented evidence the family was made aware of the results of the UA and C&amp;S and the orders for the antibiotic.</p> <p>The findings include:</p> <p>A review of the facility policy "Change in Resident Condition or Status Policy," dated December 2013, revealed the facility would promptly notify the resident, his or her attending physician, and family/responsible party of changes in the resident's condition and or status when there was a need to alter the resident's treatment significantly.</p> <p>Review of the complaint report, updated 04/03/15, revealed the complainant alleged the facility had failed to notify the family of the resident's Urinary Tract Infection. It stated the family was not aware until after the resident had been discharged on 03/22/15.</p> <p>Record review revealed the facility admitted</p>	F 157	<p>Beginning on 4/27/15, the Staff Development Coordinator will review with licensed staff on a one to one basis where and when to properly document a change in a resident's condition and/or a new physician order. Education was completed on 5/7/2015. Staff who have not yet been educated or new staff will be education prior to working the floor.</p> <p>4. Through the Quality Assurance process, the Staff Development Coordinator will audit 10 charts a month for a period 3 (three) months for proper physician/family notification documentation and proper placement of the documentation. Should any concerns be found, individual re-education will be provided to that licensed staff person. The facilities performance will be monitored thru the QA process. The QA committee consists of the Administrator, Asst. Administrator, DON, Clinical Directors, Dietitian, Activity Director, MDS Coordinator, Social Services and staff Development Nurse.</p>	5/15/2015

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F 157	<p>Continued From page 2</p> <p>Resident #1 on 12/17/14 with diagnoses which included Alzheimer's Disease, Pneumonia, Depression and Anxiety. Review of the Admission Minimum Data Set (MDS) assessment, dated 12/30/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable.</p> <p>Review of a Nursing Note, dated 03/13/15 at 8:00 AM and 8:05 AM, revealed when Resident #1 was toileted, the nurse noted the resident's urine had a foul odor. Further review of the Nursing Notes revealed the physician was notified and an order was received for a Urinalysis (UA) and Cultura and Sensitivity (C&amp;S) and the family was notified. The nurse obtained a clean catch urine specimen and the urine was amber in color. A review of a Nurse's Note, timed at 4:05 PM, revealed the results of the UA were received; the resident had four (4+) plus bacteria. A call was placed to Resident #1's physician. At 4:50 PM, the Physician called back with orders for Rocephin (an antibiotic). However, further review of the Nursing Notes revealed there was no documented evidence the family was made aware of the UA results and the Physician's Order for the antibiotic.</p> <p>Further review of the Nursing Notes, dated 03/16/15 at 12:00 noon, revealed the result of the C&amp;S was received, a call was placed to the physician, and the nurse was waiting for the physician to call back. At 11:00 PM, it was documented the physician had called back at 4:50 PM with new orders received for Levaquin (antibiotic) 500 milligrams (mg) every day time seven (7) days. However, further review revealed</p>	F 157		

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F 157	Continued From page 3 no documented evidence the family was made aware of the results of the C&S, or the new Physician's Order for the antibiotic.  Interview with Resident #1's daughter on 03/30/15 at 2:14 PM, revealed approximately one (1) week before the resident was discharged, she was told by a nurse it was suspected the resident had a UTI and a UA was ordered. However, interview with a resident's family member on 04/02/15 revealed the family was not aware of the results of the UA or that the resident was being treated with an antibiotic until after 03/22/15.	F 157		
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES  When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy it was determined the facility failed to ensure documentation of why the facility could not meet the resident's needs prior to transfer/discharge for one (1) of six (6) sampled residents (Resident #1). On 03/21/15, Resident #1 spit on Resident #6 and swatted Resident #5, and the facility made transfer plans for Resident	F 202	1. The resident affected by this deficient practice is no longer a resident in this facility.  2. On 4/14/2015, the DON review 10% of discharged residents' records to ensure that the reason/documentation for discharge or transfer was properly stated and found no further deficient practice.	

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F 202	Continued From page 4 #1 on 03/21/15, to be admitted to a Behavioral Unit at the hospital. However, record review revealed no documented evidence as to why the facility could not meet the resident's needs and no physician documentation detailing why the immediate transfer was necessary.  The findings include:  Review of the facility's policy titled, "Discharge Policy," not dated, revealed if for any reason, during the resident's stay at the facility, if the resident's condition changed, such that the resident was no longer appropriate for the facility, the family would be contacted for a care plan meeting to discuss alternate placement and care for the resident. A discharge as a result of a physician's order, will be coordinated with the receiving facility. The SS (Social Services) staff and/or Administration will assist the family and the resident in finding appropriate placement for the resident. This will be accomplished by faxing medical information to facilities requested by the family. When the resident is accepted at an alternate facility, this facility will assist the family with transportation arrangements and final discharge planning needs. Further review revealed the policy did not address the documentation requirements, per the regulation.  Record review revealed the facility admitted Resident #1 on 12/17/14 with diagnoses which included Alzheimer's Disease, Pneumonia, Depression and Anxiety. Review of the Admission Minimum Data Set (MDS) assessment, dated 12/30/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status score of three (3) which indicated the resident	F 202	3. Beginning on 4/27/15, the Staff Development Coordinator will review with licensed staff on a one to one basis the necessity of proper documentation as it pertains to transfers/discharges. As orders are received by Licensed Staff from the Physician related to transfer and discharge, the documentation will be made in the Nurses Notes and /or on a Physician's Order per conversation from the Physician, and the Physician's documentation will be available upon discharge to indicate the reason for the resident's appropriate or necessary discharge/transfer. Such reasons being: for the sake of the welfare of the resident, the resident's needs could no longer be met at this facility, or because the welfare of other residents is compromised. Education was completed on 5/7/2015. Current staff who have not been education or new staff will be education prior to working the floor.	

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F 202	<p>Continued From page 5</p> <p>was not interviewable. Further review of the clinical record revealed the resident had physical and behavioral symptoms directed at others, which included hitting, pushing, and scratching. These behaviors had occurred one (1) to three (3) days a week.</p> <p>Review of the Nurse's Note, dated 03/21/15 at 8:00 PM, revealed the facility made transfer arrangements with the Behavioral Health Unit at a local hospital, after an episode when Resident #1 became agitated and spit in the face of Resident #6 and swatted the arm of Resident #5. Review of a Physician's Order, dated 03/21/15 at 8:00 PM, revealed "Physician agrees, as family agrees, to transport the resident to the "Behavioral Health Unit" at a near-by hospital". However, review of the medical record revealed no evidence the facility had conducted an assessment to determine if new interventions would allow the facility to meet the resident's needs. In addition, record review revealed the facility failed to obtain documentation from the resident's physician to indicate why the resident's transfer was appropriate and/or necessary.</p> <p>Interview with the Social Worker (SW), on 04/01/15 at 2:33 PM, revealed the process for transferring and/or discharging a resident was, if for any reason the resident's condition change, a care plan meeting was to have been held with the family, alternate placement was to have been discussed with the family, and the physician was to have given the order for transfer and this was all to have been coordinated with the family. The SW stated Resident #1's care plan meeting scheduled with the family was scheduled for 03/23/15; however, the resident was discharged on 03/22/15 and was not in the facility at that</p>	F 202	<p>4. Through the Quality Assurance process, the Staff Development Coordinator will audit 5 charts of discharged residents a month for a period of 60 (sixty) days to verify that transfer and/or discharge orders from the Physician have been received, and the reason for the discharge is documented by the Physician. The facilities performance will be monitored thru the QA process The QA committee consists of the Administrator, Asst. Administrator, DON, Clinical Directors, Dietitian, Activity Director, MDS Coordinator, Social Services and staff Development Nurse</p> <p>5. 5/15/2015</p>	5/15/2015
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F 202	Continued From page 6  time. The SW stated she was not a part of the transfer process for this resident and this had been arranged through the Owner, Administrator and the Director of Nursing (DON,) on 03/21/15, due to an increase in the resident's combative behaviors.  Interview with the DON, on 04/02/15 at 9:30AM revealed the care plan meeting, set for 03/23/15, with the family, was made to discuss "several things" to include the resident's increase in spitting and to decide if the Memory Care Unit at the facility was "the best fit" for this resident. The DON stated on 03/21/15, she was called to come in to the facility to investigate an event surrounding Resident #1's spitting on Resident #6 and swatting Resident #5. She stated prior to this event, the resident's aggressive behaviors had been directed towards staff. The DON stated the family and the physician were called and a telephone order was received to transfer the resident to the Behavioral Unit on 03/22/15.  Interview with Resident #1's Physician, on 04/08/15 at 4:35 PM, revealed she agreed to do whatever the family wanted to do at this point and most of the phone calls received from the facility regarding this resident were made at night. She stated she had given an order, over the phone, on 03/08/15 for a Psychiatric Evaluation, yet she was not aware that the behaviors were "a big problem until I got a call that night" (03/21/15). The Physician acknowledged she had not documented in the resident's medical record the reason for the transfer/discharge of the resident.	F 202			
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	F 203	1. The resident affected by the deficient practice is no longer a resident in this facility.		

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F 203	<p>Continued From page 7</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental</p>	F 203	<p>2. On 4/17/15, The Assistant Administrator reviewed the charts of 5 discharged residents for proper notification of transfer/discharge and the proper issue of a 30-day discharge and found no further deficient practice.</p> <p>3. For any resident who is transferred or discharged from the facility, the resident and/or his responsible party will be notified in writing as soon as practicable by Social Services of the transfer or discharge. The reasons for the transfer or discharge will be documented in the Social Service Notes. A 30-day notice will be issued by Social Services or Administration to the resident and/or his responsible party unless the resident is an immediate threat to himself or others, the facility can no longer meet that resident's needs, or the resident's health sufficiently improves to allow for a more immediate discharge. The 30-day notice will contain the reason for transfer, the effective date of the transfer, the location to which the resident will be transferred, a statement that the resident has the right to appeal, and the name, address, and phone number of the State long-term care Ombudsman.</p>		

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F 203	<p>Continued From page 8</p> <p>disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #1) and/or his/her family member was notified in writing as soon as practicable when the resident was transferred/discharged. On 03/21/15, the facility determined Resident #1 required transfer/discharge arrangements to a Behavioral Care Unit, at a near-by hospital, due to the resident's increasingly combative and resistive behaviors and the resident was transferred/discharged on 03/22/15. However, the facility failed to provide a written notice to Resident #1 and/or his/her family regarding the transfer/discharge.</p> <p>The findings include:</p> <p>Review of the "Discharge Policy," undated, revealed the policy did not address notifying the resident and family/POA in writing of the transfer or discharge, per the regulation.</p> <p>Record review revealed the facility admitted Resident #1 on 12/17/14 with diagnoses which included Alzheimer's Disease, Pneumonia,</p>	F 203	<p>On 5/1/15, the Assistant Administrator educated the Social Services staff on proper notification of discharge/transfer and the issuance of a 30 day notice.</p> <p>4. Through the Quality Assurance process, the Assistant Administrator will audit 6 (six) charts a month for a period of 3 (three) months to ensure that all residents who are transferred or discharged are given proper 30 day , that the notice is issued as soon as practicable notice (where applicable), and that the documentation of the transfer or discharge is in place. The facilities performance will be monitored thru the QA process The QA committee consists of the Administrator, Asst. Administrator, DON, Clinical Directors, Dietitian, Activity Director, MDS Coordinator, Social Services and staff Development Nurse.</p> <p>5. 5/15/2015</p>	5/15/2015	

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F 203	<p>Continued From page 9</p> <p>Depression and Anxiety. Review of the Admission Minimum Data Set (MDS) assessment, dated 12/30/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status score of three (3) which indicated the resident was not interviewable. Further review revealed the resident had physical and behavioral symptoms, directed at others, which included hitting, pushing, and scratching; these behaviors occurred one (1) to three (3) days a week.</p> <p>Review of the Nurse's Notes, dated 03/21/15, revealed the facility made arrangements for Resident #1 to be transferred/discharged to a Behavioral Care Unit at the hospital due to an increase in combative behaviors. Review of a Nurse's Note, dated 03/22/15 revealed the resident was discharged on 03/22/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 03/31/15 at 11:14 AM, revealed Resident #1's family members came to the facility on 03/22/15, at approximately 8:30 AM to transport the resident to the Behavioral Care Unit and requested transfer/discharge records. The LPN stated she told the family that all information had been faxed to the receiving facility the night before and there were no records to give them.</p> <p>Review of the copy of records that were faxed to the Behavioral Care Unit on 03/21/15 revealed the twenty-four (24) page document was faxed on 03/21/15 at 10:26 PM and the result of the transmission was "OK." A review of the paperwork revealed the paperwork faxed included: the Durable Power of Attorney; Cardio-Pulmonary Resuscitation (CPR) Status; the Discharge Summary from the hospital, prior</p>	F 203			

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F 203	Continued From page 10 to the resident's admission to the facility on 12/17/14; the History and Physical from the hospital; the facility's physician discharge order, written 03/21/15 at 8:00 PM; the monthly physician orders; and a copy of the Medication Administration Record for March 2015.  Interview with the Owner of the facility, on 04/07/15 at 2:45 PM, revealed there was no paperwork given to the family upon transfer/discharge, as everything had been faxed to the Behavioral Care Unit. Per interview, even though the facility verbally informed the resident and his/her family member of the transfer/discharge, the facility failed to provide the resident and his/her family member a written transfer/discharge notice which should have included the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident was to be transferred or discharged; a statement that the resident had the right to appeal the action to the State; and the name, address and telephone number of the State Long Term Care Ombudsman.	F 203			
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR  Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph	F 205	1. The resident who was affected by the deficient practice is no longer a resident in this facility.  2. On 4/17/15, the Assistant Administrator reviewed 5 discharged records. Upon review, it was found that the bed hold policy was presented upon admission. If the resident was out of the facility for an acute stay or for therapeutic leave, the bed hold policy was presented verbally to the		

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F 205	<p>Continued From page 11</p> <p>(b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to ensure a written bed-hold notice was provided timely to one (1) of six (6) sampled residents (Resident #1) and/or his/her family member/legal representative, when the resident was transferred from the facility. Resident #1 was transferred/discharged to the Behavioral Care Unit at a hospital on 03/22/15; however, there was no documented evidence a written bed-hold notice was sent with the resident to the hospital or sent to the resident's family or legal representative.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled, "Bed Hold Policy, not dated, revealed the policy did not address when the resident and/or family/Power of Attorney was notified of the bed-hold policy and who was responsible for making them aware.</p> <p>Record review revealed the facility admitted Resident #1 on on 12/17/14 with diagnoses which included Alzheimer's Disease, Pneumonia, Depression and Anxiety.</p>	F 205	<p>to the resident and/or his/her responsible party. A copy of the bed hold policy was not presented to the resident or his/her responsible party within 24 hours of that resident leaving the facility.</p> <p>3. The facility has implemented a Bed Hold and Notification Policy. Upon admission to the facility the resident and/or his responsible party will be informed by Social Services and/or Administration of the facility's bed hold policy. If a resident leaves the facility for therapeutic leave or to an acute care setting, the resident and/or his family will be contacted with 24 hours of the resident's leave and will be given each option for holding the bed in the facility. If the facility's bed hold policy should change at any point during that resident's stay, the bed hold policy will be issued. On 5/1/15, the Assistant Administrator educated the Social Services staff on the purpose of the Bed Hold and Notification Policy and on the delivery/issuance of the policy.</p>		

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F 205	<p>Continued From page 12</p> <p>Review of the Nurse's Notes, revealed the Resident #1 was transferred/discharged to the Behavioral Care Unit, at a near-by hospital, with a family member on 03/22/15. Further record review revealed there was no evidence of a written bed-hold notice being sent with the resident, resident's family, or legal representative.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 03/31/15 at 11:14 AM, revealed Resident #1's family members came to the facility on 03/22/15, at approximately 8:30 AM to transport the resident to the Behavioral Care Unit at the hospital and requested transfer/discharge records. The LPN stated she told the family that all information had been faxed to the receiving facility, the night before and there were no records to give them. A review of the records faxed to the Behavioral Care Unit revealed there was no Bed-Hold notice included in the paperwork.</p> <p>Interview with Resident #1's family members, on 03/30/15 at 1:55 PM, revealed the family members received no discharge paperwork to include a bed-hold notice, when they arrived on 03/22/15 at approximately 8:30 AM, to transfer the resident.</p> <p>Interview with the the Administrator, on 04/07/15 at 2:25 PM and 2:35 PM, revealed the administrator was unaware if the resident or resident's family received a copy of the bed-hold notice or who should have provided this to the resident.</p> <p>Interview with the Owner of the facility, on 04/07/15 at 2:45 PM and 4:58 PM, revealed the</p>	F 205	<p>4. Through the Quality Assurance process, the Assistant Administrator will audit 6 (six) charts a month for a period of 3 (three) months to ensure that the bed hold policy was presented to the resident and/or his family/responsible party upon admission, within 24 hours of the resident's leave from the facility, and if the bed hold policy should have changed. The facilities performance will be monitored thru the QA process. The QA committee consists of the Administrator, Asst. Administrator, DON, Clinical Directors, Dietitian, Activity Director, MDS Coordinator, Social Services and staff Development Nurse.</p> <p>5. 5/15/2015</p>	5/15/2015	

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F 205	Continued From page 13 resident's family was not given a copy of the bed-hold notice, as she was trying to protect other residents by getting Resident #1 where he/she needed to be at that time. She stated if a resident goes to the hospital, the facility's past practice was to call the family the next day, after the resident got settled into the hospital. Per interview, the facility would call to inquire about a bed-hold and she thought it was more considerate than asking the family, during the transfer, if they would sign a form. She stated she "had 24 hours to get this paperwork completed and the whole process had disintegrated at that point" and the bed-hold information was not provided to the resident's family. Further interview revealed she could not say who was responsible to ensure the resident had a copy of the facility's Bed Hold Policy, prior to discharge, only that the facility's practice was to make a phone call or contact with the responsible party, to inquire if they wanted to hold the bed until the resident returned for a fee.	F 205			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, the facility's protocol, and review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14, it was determined the facility failed to ensure services provided met professional standards of care for one (1) of six (6) sampled residents (Resident #1), related to not following physician's orders, while administering medications.	F 281	1. The resident affected by the deficient practice is no longer a resident in this facility.  2. On 4/14/2015, the DON observed medication administration for the proper administration of medications per Physician order and found no further deficient practice.		

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F 281	<p>Continued From page 14</p> <p>Resident #1 was administered whole medications, on 03/22/15, when it was ordered to administer crushed as needed, which resulted in the resident not receiving the last dose of an antibiotic because the resident kept spitting the medication out.</p> <p>The findings include:</p> <p>Review of the Kentucky Board of Nursing AOS #14, last revised 10/2010, revealed licensed staff should administer medication and treatment as prescribed by the physician and advanced practice registered nurse.</p> <p>Interview with the Director of Nursing, on 04/07/15 at 4:45 PM, revealed the policy for crushing medications was to follow the physician's order and the undated "Do not crush list for medications."</p> <p>Record review revealed the facility admitted Resident #1 on 12/17/14 with diagnoses to include Alzheimer's Disease, Pneumonia, Depression and Anxiety.</p> <p>Review of the March 2015 Physician's Orders revealed to crush medications, as needed and a pureed diet. Additionally, review of a Physician's order, dated 03/16/15, revealed to administer Levaquin (antibiotic) 500 milligrams (mg) every day, for seven (7) days, for treatment of a Urinary Tract Infection (UTI.)</p> <p>Review of the March 2015 Medication Administration Record (MAR), revealed the last dose of the antibiotic would have been administered on 03/22/15. The medication had not been circled on the MAR as refused, but had</p>	F 281	<p>3. The facility will ensure that the services provided will meet professional standards related to following the Physician's Orders while administering medications. Staff was educated with the use of pharmacy recommendations on the medications that may be crushed. Beginning 4/29/15, the Staff Development Coordinator will review with Licensed staff the Kentucky Board of Nursing AOS #14 directive that a licensed nurse should administer medication and treatment as prescribed by the Physician and Advanced Practice Registered Nurse. Education was completed on 5/7/15. Staff not educated will receive proper education prior to working the floor.</p>		

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F 281	Continued From page 15 been initialed as given.  Interview with Licensed Practical Nurse (LPN) #2, on 03/31/15 at 11:05 AM, revealed on the morning of 03/22/15 at approximately 8:30 AM, she attempted to administer the last dose of the resident's antibiotic. The LPN stated two (2) family members were there to escort the resident to another facility that morning and one (1) of the resident's sons had requested the LPN to not crush the resident's medication. The LPN revealed the resident rolled the medication around in his/her mouth for quite some time and the LPN was unsure how much of the medication the resident did, or did not, actually receive. Per interview the resident kept spitting the medication out. The LPN revealed she did not make any further attempts to administer the medication.  Interview with the DON, on 04/07/15 at 4:45 PM, revealed the resident's medications had been crushed since he/she had been admitted and the DON would have expected them to have been administered this way.  Interview with the Physician, on 04/07/15 at 5:00 PM, revealed she would have expected the medications to have been given crushed, as this was how they were ordered.	F 281	4. Through the Quality Assurance process, the Staff Development Coordinator will audit 5 (five) residents a month for a period of 60 (sixty) days thru direct observation of medication passes to ensure that medications have been properly administered per MD order. The facilities performance will be monitored thru the QA process. The QA committee consists of the Administrator, Asst. Administrator, DON, Clinical Directors, Dietitian, Activity Director, MDS Coordinator, Social Services and staff Development Nurse.  5. 5/15/2015	5/15/2015	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	1. The resident affected by the deficient practice is no longer a resident in this facility.  2. On 4/14/2015, the DON reviewed 10% of the clinical records to ensure that services were rendered according to the written plan of care and found no further deficient practice.		

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F 282	<p>Continued From page 16</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 provide services according to the written plan of care for one of six (6) sampled residents (Resident #1). Resident #1 was care planned to consult with the Psychologist, per physician orders; however, the Licensed Practical Nurse (LPN) #1 failed to write the verbal order for a Psychiatric Evaluation on the physician's orders on 03/09/15. The Consultant Psychiatrist required a physician's order and consent to provide the evaluation; however, when he visited the facility on 03/19/15, there was no physician's order and consent form in the resident's chart so he could conduct the evaluation. On 03/21/15, the facility determined Resident #1 required transfer/ discharge arrangements to a Behavioral Care Unit, at a near-by hospital, due to the resident's increasingly combative and resistive behaviors and the resident was transferred/discharged on 03/22/15.</p> <p>The findings include:</p> <p>A review of the "Care Plan Policy," undated, revealed the policy did not address implementation of the interventions of the care plan.</p> <p>Record review revealed the facility admitted Resident #1 on 12/17/14 with diagnoses which included Alzheimer's Disease, Pneumonia, Depression and Anxiety. Review of the Admission Minimum Data Set (MDS) assessment, dated 12/30/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status</p>	F 282	<p>3. The facility will ensure that all orders received from the Physicians are accurately transcribed by licensed staff onto a Physician Order in the medical record and/or are noted in the Nurses Notes. Beginning on 4/27/15, the Staff Development Coordinator will review with licensed staff on a one to one basis the necessity of accurate transcription of physician orders as it pertains to implementation of care plans. The education was completed on 5/7/15 and all staff will be educated prior to working the floor.</p> <p>4. Through the Quality Assurance process, the Staff Development Coordinator will audit 5 (five) charts a month for a period of 60 days to ensure that orders received from the Physicians pertaining to the plan of care are being accurately transcribed. The facilities performance will be monitored thru the QA process. The QA committee consists of the Administrator, Asst. Administrator, DON, Clinical Directors, Dietitian, Activity Director, MDS Coordinator, Social Services and staff Development Nurse.</p> <p>5. 5/15/2015</p>	5/15/2015	

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F 282	<p>Continued From page 17</p> <p>score of a "3" which indicated the resident was not interviewable. Further review revealed the resident had physical and behavioral symptoms, directed at others, which included hitting, pushing, and scratch and they occurred one (1) to three (3) days a week.</p> <p>Review of the Comprehensive Care Plan for behaviors, dated 12/19/14, revealed the resident had behaviors of wandering and the potential for social isolation, due to being a new admission. The care plan for the use of antidepressant medications, dated 12/29/14, revealed an intervention to consult with the Psychologist, per physician orders. A Comprehensive Care Plan for socially inappropriate behaviors, dated 12/30/14, revealed the resident exhibited socially, physically, verbally abusive behaviors and episodes of spitting, with interventions to allow a quiet and calm environment during an acute phase; remove from anger-inducing situations immediately; watch interactions with others to prevent physical outbursts and charting any abnormal behaviors. In addition, the resident was to be redirected should he/she have entered another resident's room, and the staff were to have kept the resident away from other residents during hostile phases.</p> <p>Review of the Nursing Notes, dated 03/09/15 at 3:00 PM, revealed Licensed Practical Nurse (LPN) #1 documented a call received from the physician for a psychiatric evaluation for Resident #1. However, further review revealed the physician's telephone order was never transcribed on the physician orders section of the medical record.</p> <p>Interview with LPN #1, on 04/06/15 at 4:00 PM</p>	F 282			

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F 282	Continued From page 18 and 4:28 PM, revealed she should have written the order, on the Physician Order Form and not just in the nursing notes. The LPN stated she spoke with the Consultant Psychologist, who was at the facility on 03/19/15, and the Consultant never asked about the physician's order or a consent form and she thought the Consultant had already completed the evaluation of the resident.  Interview with the Consultant Psychologist, on 04/02/15 at 3:15 PM and on 04/03/15 at 8:35 AM, revealed because there was no physician's order in the chart he was unable to evaluate the resident.  Interview with the Director of Nursing (DON), on 04/07/15 at 4:58 PM, revealed the order was received and the Psychologist was made aware of the need for the visit. However, the physician order had not been written and the resident did not receive a psychiatric evaluation per the care plan.  Interview with the facility's Owner, on 04/07/15 at 4:55 PM, revealed she was unaware the psychiatric evaluation had not been completed, until recently and this should have been done.  Interview with the Resident #1's Physician, on 04/07/15 at 5:20 PM and 04/08/15 at 4:35 PM, revealed she ordered a psychiatric evaluation to evaluate the increase of spitting and combative behaviors and stated she would have expected this to have been carried out per the care plan.	F 282			
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES  Based on the comprehensive assessment of a	F 319			

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F 319	<p>Continued From page 19</p> <p>resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a resident who displayed mental or psychosocial adjustment difficulty, received the appropriate treatment and services, regarding a Psychiatric Evaluation, for one of six (6) sampled residents (Resident #1). The physician ordered Resident #1 a psychiatric evaluation on 03/09/15 due to the resident's increased behaviors of spitting, combativeness and resistive behaviors; however, the facility failed to ensure the evaluation was completed. The resident's behaviors continued to increase and on 03/21/15, the facility determined Resident #1 required transfer/discharge to a Behavioral Care Unit, at a near-by hospital. The resident was transferred/ discharged on 03/22/15 and as of 03/22/15, the psychiatric evaluation had not been conducted.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 12/17/14 with diagnoses which included Alzheimer's Disease, Depression and Anxiety. Review of the Admission Minimum Data Set (MDS) assessment, dated 12/30/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status score of a "3" which indicated the resident was not interviewable. Further review revealed the resident had physical and behavioral</p>	F 319	<p>1. The resident affected by the deficient practice is no longer a resident in this facility.</p> <p>2. On 4/14/2015, the DON reviewed 10% of the clinical records to ensure that the plan of care was being followed for those residents who receive services for psychosocial or adjustment difficulty and found no further deficient practice.</p> <p>3. The facility will ensure that all residents who display mental or psychosocial adjustment difficulty will receive appropriate treatment and services. Licensed staff will contact the MD for a Physician's Order for the service indicated by the resident's condition. The facility will ensure that all orders received from the Physicians are accurately transcribed by licensed staff onto a Physician Order in the medical record and/or are noted in the Nurses Notes.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185227</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUPERIOR CAREHOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 MARSHALL COURT PADUCAH, KY 42001</b>		
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F 319	<p>Continued From page 20</p> <p>symptoms, directed at others, which included hitting, pushing, and scratch and they occurred one (1) to three (3) days aweek.</p> <p>Review of the Nursing Notes revealed on 03/09/15 at 11:00 AM, the resident was spitting on the floor and on self and at 1:30 PM, the resident had increased anxiousness and was repeatedly stating "I'm dying". The son was made aware of a request for a "Psych Consult" due to increased spitting behavior and stated he agreed to whatever the physician wanted because he had noted an increase in spitting also. At 3:00 PM, LPN #1 documented she received a call from the physician with an order for a psychiatric evaluation for Resident #1. However, review of the Physician's Orders revealed the telephone order for the psychiatric evaluation was never transcribed on the physician orders section of the medical record.</p> <p>Interview with Licensed Practical Nurse (LPN)#1 on 04/06/15 at 4:00 PM and 4:28 PM, revealed she should have written the order, on the Physician Order Form and not just in the nursing notes. The LPN stated she had spoken with the Consultant Psychiatrist, who was at the facility on 03/19/15, regarding Resident #1's increased spitting behaviors and was told "spitting was a habit and there was no medication that was going to fix that." She revealed the Consultant never asked about the physician's order or consent form and she thought the Consultant had already completed the evaluation of the resident.</p> <p>Further review of the Nursing Notes revealed the resident's behaviors of spitting and combativeness continued to increased. On 03/11/15 at 2:15 PM, Resident #1 was yelling and</p>	F 319	<p>Beginning on 4/27/15, the Staff Development Coordinator will review with licensed staff on a one to one basis the necessity of properly documenting physician's orders as they pertain to professional services (i.e. psychiatric evaluations). The education was completed on 5/7/15. All staff will be educated prior to working the floor.</p> <p>4. Through the Quality Assurance process, the Staff Development Coordinator will audit 5 (five) charts a month for a period of 60 days to ensure that orders received from the Physicians are being accurately transcribed. The facilities performance will be monitored thru the QA process. The QA committee consists of the Administrator, Asst. Administrator, DON, Clinical Directors, Dietitian, Activity Director, MDS Coordinator, Social Services and Staff Development Nurse</p> <p>5. 5/15/2015</p>	5/15/15	

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NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MARSHALL COURT PADUCAH, KY 42001		
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F 319	<p>Continued From page 21</p> <p>cursing at staff during morning care. It was documented the resident's spitting behavior had continued but was somewhat better since started on Mucinex (decongestant). On 03/13/15 at 5:00 AM, the resident was noted to have been awake all night talking and spitting. At 6:00 AM, Resident #1 was found trying to bite another resident. Resident #1 was redirected and removed away from the other resident. At 10:30 PM, it was documented the resident was spitting constantly, yelling out, and trying to fight staff when receiving care. On 03/17/15 at 5:45 PM, the Certified Nursing Assistant (CNA) found Resident #1 holding on to another resident's arm and it was documented the resident was easily redirected. The resident was taken to the bathroom and the resident was yelling and hitting at staff. The nurse documented she was able to easily redirect the resident. On 03/18/15 at 5:00 AM, the resident was repeatedly calling staff names and say "I'm going to hit you and bust your head". Resident redirected multiple times. However, further review of the medical record revealed there was no evidence a Psychiatric Consultant was conducted.</p> <p>Interview with the Consultant Psychologist, on 04/02/15 at 3:15 PM and 04/03/15 at 8:35 AM, revealed he routinely made bi-monthly visits to the facility to monitor residents. He stated he received a call from the facility on 03/16/15 to evaluate Resident #1 and was able to come to the facility on 03/19/15. However, he stated he was unable to evaluate the resident, as there was no physician's order in the chart and he did not find a consent for treatment form, signed by the resident's POA. He stated, according to the consultant contract with the facility, he was not allowed to evaluate the resident without having</p>	F 319			

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F 319	<p>Continued From page 22 first obtained these forms.</p> <p>Review of the Consent To Treatment Form, undated, revealed a verbal consent was received from the Power of Attorney (POA) on 03/19/15, for Resident #1 to be treated by the psychology consultants, to allow the consultants to develop a treatment plan, and to regularly review the treatment goals in the resident's best interest.</p> <p>Interview with the Social Worker (SW), on 04/01/15 at 2:33 PM and a review of the Notice of Privacy Practice and Consent For Treatment Form, dated 03/19/15 revealed the SW obtained verbal consent, over the phone, for the Psychiatric Evaluation, on 03/19/15 from the resident's POA. She was unsure of the exact time of the phone call and there was no documentation in the Social Services Progress Notes or the nurses notes regarding the call.</p> <p>Review of the Nursing Notes, dated 03/20/15 at 2:30 PM, revealed the resident was in a foul mood in the morning and spit in the nurse's face. Review of a Nurse's Note, dated 03/21/15 at 4:30 PM, revealed Resident #1 had increased agitation on this shift with repeatedly cursing at staff and other residents. The resident was observed to spit in another resident's face by a CNA. Redirection was attempted with little success. The resident was then observed to "swat" at another resident. The resident was taken to his/her room and the nurse sat with the resident and listened to music. The Administration, Physician and family were notified. However, further review of the Medical Record revealed there was no evidence the resident ever received a psychiatric evaluation.</p>	F 319		
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F 319	Continued From page 23 Interview with the Director of Nursing (DON), on 04/07/15 at 4:58 PM, revealed the order was received and the Psychologist was made aware of the need for the visit. However, the physician order had not been written and the resident did not receive a psychiatric evaluation.  Interview with the facility's Owner, on 04/07/15 at 4:55 PM, revealed she was unaware the psychiatric evaluation had not been completed, until recently and this should have been done.  Interview with Resident #1's Physician, on 04/07/15 at 5:20 PM and 04/08/15 at 4:35 PM, revealed the resident had experienced behaviors of spitting for years. However, the physician stated she was "not a psychiatrist" and she ordered a psychiatric evaluation to evaluate the increase of spitting and combative behaviors and stated she would have expected this to have been carried out.	F 319			