STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185294	A. BUILDING _____ B. WING _____	R 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MAPLE	515 GREENE DRIVE GREENVILLE, KY 42345

(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/22/13 as alleged	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	185294	A. BUILDING _____ B. WING _____	10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MAPLE	515 GREENE DRIVE GREENVILLE, KY 42345

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F 000	INITIAL COMMENTS A Recertification survey was conducted 10/16/13 through 10/18/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of a "D".	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
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, and facility policy review it was determined the facility failed to ensure professional standards of practice were met related to following the physician's order for one (1) of eighteen (18) sampled residents (Resident #11). The facility failed to administer medication per doctor order for three days for Resident #11. The findings include: Review of the facility policy titled, "Medication Administration", dated 08/31/12, revealed if a discrepancy is noted, compare the medication record to the physician orders in the resident's medical record. Document administration and/or refusal of the medication after the administration and/or the attempt to administer the medication on the Medication Administration Record (MAR), and update the controlled drug record for a Schedule II drug, if applicable. Review the MAR at the end of each medication pass to ensure necessary doses were administered and	F 281	F281 1) The licensed nurse who failed to administer medication for resident #11 received appropriate human resource action procedures. 2) The Director of Nursing, Unit Manager, and Medical Records nurse will conduct an audit of the October 2013 medication records to identify any other residents that may not have medications initialed. 3) The Staff Development Coordinator will conduct and in-service with licensed nurses and Certified Medication Aids regarding medication administration with emphasis on initialing the medication administration record after administering a medication. 4) The Staff Development Coordinator will conduct two random medication pass observations weekly for three months to ensure staff is meeting professional standards of clinical practice and compliance with the facility Medication Administration policy. Results of the medication pass audits will be brought to the PI meetings for discussion monthly for three months.	11/22/20 13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — (X6) DATE

Executive Director 11-7-13

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	185294	A. BUILDING _____ B. WING _____	10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MAPLE	515 GREENE DRIVE GREENVILLE, KY 42345

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F 281	Continued From page 1 document. Record review revealed the facility admitted Resident #11 on 01/29/13 with diagnoses to include Dementia with behavioral disturbances, Unspecified Transient Cerebral Ischemia, Muscle Weakness, and Adult Failure to Thrive. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/13 revealed the facility assessed Resident #11's cognition as severely impaired. Review of a Medication Regimen Review, dated 10/04/13, revealed Resident #11 to have been assessed for a decrease in Seroquel (anti-psychotic) to 12.5 milligrams (mg.) every day for five (5) days. Review of a Physician's telephone order, dated 10/04/13 at 1900, revealed a gradual dose reduction for Resident #11 to receive Seroquel 12.5 mg. at hour of sleep for five (5) days then discontinue order. Review of the October 2013 MAR revealed there were no initials to indicate Resident #11 received Seroquel 12.5 mg. on 10/06/13, 10/07/13 and 10/08/13 at hour of sleep per order. Interview with the Director of Nursing (DON), on 10/18/13 at 12:25 PM, revealed the Medication Administration Record (MARS) indicated Resident #11 was not given Seroquel 12.5 mg. for three days and it should have been given.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 2 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy and procedure review it was determined the facility failed to ensure interventions were followed according to comprehensive care plan for one (1) of eighteen (18) sampled residents (Resident #11). Resident #11 was care planned to be provided a baby doll for sensory and calming, and to hold and care for. The findings include: Review of the facility policy and procedure titled, "Care Plans", dated 01/07/13 revealed "A comprehensive care plan is developed consistent with the patients' specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services, and timetables to meet the patient's needs as identified in the patient's assessment or as identified in relation to the patient's response to the interventions or changes in the patient's condition. Plan of care is developed on the patient's individual needs as identified by assessments. The care plan includes a treatment plan, patient's preference, patient goals that are measurable and contain a schedule to evaluate the patient's progress or lack of progress toward his/her goals. Record review revealed the facility admitted Resident #11 on 01/29/13 with diagnoses to	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F282 1) The care plan for resident #11 was reviewed and revised to ensure appropriate interventions were care planned and implemented by staff; 2) An audit of all facility residents' Kardex/care plan will be conducted by the Activity Coordinator, Director of Nursing, Social Service Coordinator, Unit Manager, MDS Coordinator, Case Manager, Licensed Nurse Scheduler, Medical Records licensed nurse, and Program Development Coordinator. 3) Staff will be educated on following the resident's plan of care. 4) Angels will conduct three random audits weekly for three months to validate that the care plans are being followed. Findings will be brought to the PI committee monthly for three months.	11/22/2013

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F 282	Continued From page 3 include Dementia with behavioral disturbances, Unspecified Transient Cerebral Ischemia, Muscle Weakness, and Adult Failure to Thrive. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/13 revealed the facility assessed Resident #11's cognition as severely impaired. Review of Resident #11's Comprehensive Care Plan for activities, dated 02/04/13, revealed an intervention to provide a "baby doll" for sensory and calming. Further review revealed a care plan for depression and psychosis, dated initiated on 01/31/13 and 2/14/13, revealed an intervention to offer Resident #11 a baby doll to hold and to offer baby doll to care for. Observation on 10/16/13 at 10:10, 3:10 PM, and 3:45 PM, on 10/17/18 at 9:00 AM, 11:00 AM, and 1:40 PM and on 10/18/13 at 10:00 AM, 10:15 AM, and 10:45 AM revealed Resident #11 did not have a baby doll with him/her. Observation on 10/18/13 at 10:45 AM revealed there was a baby doll sitting on the shelf of Resident #11's closet. Interview with the Director of Nursing (DON), on 10/18/13 at 12:25 PM, revealed she would give the baby doll to Resident #11 if she was upset to soothe her.	F 282		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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F 441	Continued From page 4 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy and procedure review it was determined the facility failed to ensure staff followed practiced proper hand hygiene practices	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 441 1) The nursing staff involved in touching objects in the residents room and not washing hands and re-gloving prior to providing care to the resident was re-educated . 2) An infection control audit was conducted throughout the facility by the Infection Control Nurse to identify any other infection control concerns. 3) Staff will be re-educated on Hand Hygine/Handwashing policy dated 8/31/2011 with emphasis on washing hands and re-gloving prior to providing care, to include peri care and skin assessments, on a resident when objects in the room have been accidentally touched. 4) The infection Control Nurse will Conduct two peri care and two skin assessment audits weekly to observe for infection control concerns. This data will be reviewed and analyzed by the DNS weekly and brought to PI meeting monthly for three months.	11/22/2013

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F 441	Continued From page 5	F 441		

while providing perineal care and a skin assessment to one (1) of eighteen (18) sampled residents (Resident #11). Staff failed to wash hands and change gloves after touching the privacy curtain, the blinds, turned the over the bed light on, and touched the bed remote prior to providing care for Resident #11.

The findings Include:

Review of the facility policy titled, " Hand Hygiene/Handwashing", dated 08/31/11, revealed "Hand hygiene is performed before taking part in a medical or surgical procedure; after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn; and intermittently after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. The policy further states under Procedure, Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient/patient".

Record review revealed the facility admitted Resident #11 on 01/29/13 with diagnoses to include Dementia with behavioral disturbances, Unspecified Transient Cerebral Ischemia, Muscle Weakness, and Adult Failure to Thrive. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/13 revealed the facility assessed Resident #11's cognition as severely impaired.

Observation during a skin assessment and incontinent care, on 10/17/13 at 1:40 PM, revealed Licensed Practical Nurse (LPN) #1 turned applied gloves then turned on the light

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F 441	Continued From page 6 over the bed and the LPN did not change gloves or wash hands before providing perineal care and skin assessment to Resident #11. Further observation revealed the Certified Nursing Assistant (CNA) #1 did not change gloves or wash hands before assisting with the skin assessment and perineal care of Resident #11 after touching and pulling the privacy curtain closed. Interview with CNA #1, on 10/17/13 at 11:40 PM, revealed if staff touched anything, such as curtains in the resident's room, the staff should wash hands and change gloves to help control infection. Interview with LPN #1, on 10/17/13 at 3:05 PM, revealed staff should change gloves if touching objects in the resident's room after applying gloves and before providing care to a resident. Interview with the Director of Nursing (DON), on 10/18/13 at 12:25 PM, revealed if nursing staff touches objects in a patient's room they should go back and change their gloves and wash hands before providing care to the resident.	F 441		

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	185294	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MAPLE	**515 GREENE DRIVE** **GREENVILLE, KY 42345**

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1964. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (211). SMOKE COMPARTMENTS: Five (5) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1964, upgraded in 2009 with 38 smoke detectors and 8 heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1964. GENERATOR: Type II generator installed in 1965. Fuel source is Propane. A standard Life Safety Code survey was conducted on 10/17/13. Kindred Nursing and Rehab- Maple Manor was found in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Ninety-Five (95) beds with a census of Eighty-Nine (89) on the day of the survey. The findings demonstrate compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 11/7/13

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	185294	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/17/2013**

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