

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

PRINTED: 06/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/16/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	
(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		
F 514 SS=D	<p>The Abbreviated Survey to investigate KY#00023086 was initiated on 04/14/15 and concluded on 04/16/15. The allegation was unsubstantiated with a related deficiency cited.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure clinical records were maintained for each resident in accordance with accepted professional standards and practices, and were complete and accurately documented, for one (1) of five (5) sampled residents (Resident #4). Record review revealed staff failed to accurately document Resident #4's daily fluid intake on the hydration records in order to determine if the resident was receiving a</p>	F 514		

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

TITLE

(X6) DATE

05/08/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/16/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(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 514	<p>Continued From page 1</p> <p>sufficient amount of fluids daily to maintain proper hydration.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Hydration", dated 12/2010, revealed it was the intent of the facility to ensure residents received sufficient amounts of fluid to maintain proper hydration.</p> <p>Record review revealed Resident #4 was admitted by the facility on 08/16/12 with diagnoses which included a history of Urinary Tract Infection, Dysphagia-Oropharyngeal (difficulty swallowing), Dementia, Depression, Urinary Retention and Acute Kidney Failure. Review of Resident #4's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 01/14/15, revealed a Brief Interview for Mental Status score of eleven (11), which indicated the resident was moderately cognitively impaired.</p> <p>Review of the Comprehensive Care Plan revealed Resident #4 was at risk for fluid volume deficit related to decreased intake, with interventions in place to monitor the resident for symptoms of dehydration.</p> <p>Review of the April 2015 Medication Administration Record (MAR) revealed Resident #4 was to be assessed every shift for signs and symptoms of dehydration; however there was no documented evidence the resident was assessed as ordered for eight (8) shifts between 04/01/15 and 04/14/15. Continued review of the April 2015 MAR revealed Resident #4 was ordered a between-meals beverage three (3) times a day. However, there was no documented evidence the additional beverages were provided for eight (8)</p>	F 514			

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

PRINTED: 06/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/16/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(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 514	<p>Continued From page 2</p> <p>shifts between 04/01/15 through 04/14/15. Further review of the MAR revealed Resident #4 was to be encouraged to consume 240 milliliters (ml) with each medication pass, or four (4) times per day. Nursing staff did initial the fluids were offered with each medication pass, but failed to document the actual amount the resident consumed with the medication pass between 04/01/15 and 04/14/15.</p> <p>Review of the facility's computerized documentation for fluid intake with meals revealed no documented evidence Resident #4 consumed any fluids with meals on 04/07/15. Review of computer documentation for "Additional Fluid Intake" revealed the amount consumed was documented on only three (3) occasions between 04/01/15 and 04/14/15.</p> <p>Review of the "Hydration Requirements" form utilized by the facility revealed it stated if the minimum recommended daily allowance of 1500 ml of fluid was not met, the form was to be initiated. Continued review revealed if the minimum allowance was not met after the third day, the Physician was to be notified. The "Hydration Requirements" form was initiated once for Resident #4 between 04/01/15 and 04/14/15, on 04/10/15 with a documented fluid consumption of 1200 ml. Subsequently, documentation revealed fluid consumption of 1320 ml on 04/11/15 and 960 ml on 04/12/15. However, there was no documented evidence the Physician was notified as directed. Further review of fluid consumption from all forms of documentation for 04/10/15 through 04/12/15 revealed Resident #4's fluid intake was actually more than 1500 ml each day. Conversely, actual documented fluid intake for 04/01/15 through 04/05/15 revealed</p>	F 514			

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

PRINTED: 06/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/16/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(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 514	<p>Continued From page 3</p> <p>consumption was less than 1500 ml per day; however, no "Hydration Requirements" form was initiated for that time span. Continued review of Resident #4's documented intake according to the MAR, the computerized "meal intake" amounts and "additional fluid" amounts revealed the facility did not have an effective system for accurately documenting actual fluid consumption. Therefore, it was impossible to monitor resident #4's intake to determine whether or not fluid requirements were met, and if additional interventions were required.</p> <p>Interview with the Dietician, on 04/16/15 at 10:00 AM, revealed she determined average daily fluid intake from reviewing _____ documented consumption for the past seven (7) days, and she based her recommendations on those figures. She stated she was aware of several different forms where fluid intake was documented and she had noticed inconsistency and inaccuracy in documentation of residents' fluid intake. Continued interview revealed it was important for fluid intake to be accurately documented so recommendations would be appropriate for each resident's needs.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #2, on 04/16/15 at 4:00 PM, revealed staff were supposed to enter the fluid intake information on the computer kiosk. She stated she knew Resident #4 and believed he/she drank an adequate amount of fluids every day, but reported some staff failed to document all the fluids consumed.</p> <p>Interview with SRNA #3, on 04/16/15 at 4:18 PM, revealed staff were supposed to document fluid intake at meal times, and fluids consumed at</p>	F 514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/16/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(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 514	<p>Continued From page 4</p> <p>other times throughout the day. She stated liquid dietary supplements were also to be documented on the computer kiosk. Continued interview revealed SRNA #3 was aware fluid intake numbers were not always accurate because staff sometimes failed to enter all consumed fluids in the computer.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/16/15 at 5:00 PM, revealed the SRNAs were responsible for documenting food and fluid intake in the computer at meal times. In addition, any fluids consumed other than at meal time were also to be documented in the computer kiosk on the "Additional Fluids" form. She stated the nurses and Activity staff also had access to document fluids in the kiosk. Continued interview revealed the nurses often documented fluid consumption on the MAR but did not document in the computer. She further stated she did not think all staff were documenting fluid intake consistently in the same way, which allowed for inaccuracy, making it difficult to know exactly how much a resident actually consumed in fluid form. Further interview revealed the Physicians usually ordered laboratory tests if the documentation showed decreased fluid intake; however, she stated she felt most of the time it was inaccurate documentation instead of insufficient intake. Continued interview revealed LPN #1 was very familiar with Resident #4, and knew the resident drink a lot of fluids with and between meals. She acknowledged it did not appear all the fluids were documented because she saw the resident consuming fluids frequently, and he/she did not show any signs of dehydration.</p> <p>Interview with the Registered Nurse (RN) Unit Manager, on 04/16/15 at 6:14 PM, revealed the</p>	F 514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/16/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(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 514	<p>Continued From page 5</p> <p>SRNAs were to document fluid intake during meals on the computer kiosk. She stated any fluids consumed other than at mealtime should also be documented on the "Additional Fluids" form on the computer. Further interview revealed the nurses documented supplements and additional fluids on the MAR, but reported extra fluids ordered and transcribed to the MAR should also be documented by the nurses in the kiosk. Further interview revealed fluids documented in the computer were calculated and were the basis of interventions including Physician notification of less than adequate intake. She also stated the fluid totals were used for discussion during the facility's daily morning meeting to determine if a resident needed closer monitoring. Continued interview revealed the Unit Manager realized there was inaccuracy in the fluid intake documentation and she recognized it as a failure in the process. She stated it was her expectation for staff to accurately document the residents' fluid intake because it was important to know if the residents were maintaining adequate hydration. Further interview revealed she knew Resident #4 drank adequate amounts of fluids daily; if that was not reflected by a review of fluid totals, it was a failure in the documentation.</p> <p>Interview with the Director of Nursing (DON), on 04/16/15 at 9:20 AM, revealed she was aware all nursing staff were not consistently documenting fluid intake on all facility forms, making it difficult to accurately assess actual fluid consumption. Subsequent interview, on 04/16/15 at 6:50 PM, revealed it was her expectation for fluid intake to be accurately documented. She stated she felt facility staff would benefit from re-education related to accurate documentation on the medical record.</p>	F 514			

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

PRINTED: 06/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/16/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(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 514	Continued From page 6 Interview with the Administrator, on 04/16/15 at 7:18 PM, revealed hydration was discussed daily during the morning meeting, and a list of residents not meeting their fluid requirements was reviewed. Continued interview it was the Administrator's expectation for fluid intake records to be accurate in order to ensure appropriate interventions were initiated. He stated he felt the breakdown was in getting all staff to document consistently in the computer kiosk.	F 514			