

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

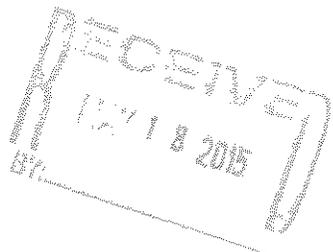
PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/03/2015
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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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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	INITIAL COMMENTS A Recertification Survey was initiated on 03/31/15 and concluded on 04/02/15. Deficiencies were cited with the highest Scope and Severity of "E".	F 000		5/18/15
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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. 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 revised for one (1) of eleven (11) sampled residents (Resident #4) who were reviewed for	F 280	Harrodsburg Health and Rehabilitation Center does not believe and does not admit that any deficiencies existed before, during, or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or any other legal proceedings. This allegation of compliance is not intended to and does not establish any standard of care, contract obligation, or position, and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this allegation of compliance should be considered or relied upon as a waiver of any potentially applicable Peer Review, Quality Assurance, self-critical examination, or any other legal privileges in any administrative, civil or criminal claim, action or proceeding. The Facility offers in response, credible allegations of compliance, and plan of correction as part of its ongoing efforts to provide quality of care to residents.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Penny Lepton</i>	TITLE Administrator	(X6) DATE 5-18-15
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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 280	Continued From page 1 care plans, out of a total sample of nineteen (19) residents. Resident #4 had a history of constipation, with no documented evidence the resident experienced bowel movements for six (6) days, for three (3) different time spans during the months of February and March 2015. However, the Comprehensive Care Plan was not revised related to the resident's constipation. The findings include: Review of the facility's "Care Plans-Comprehensive" policy, revised October 2010, revealed assessments of residents were ongoing and care plans were to be revised as information gathered about the resident and the resident's condition changed. Continued review revealed the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when a desired outcome was not met. Review of the facility's policy titled "Interdisciplinary Team Care Assessments", effective date 12/2010, revealed "changes in a resident's condition often require changes to be made in the plan of care either by change in individual approaches or by the addition of new problems to the plan of care". Continued review of the policy revealed when changes in condition, medications, treatments or approaches occurred, the plan of care was to be updated immediately. Review of the facility's "BM Regimen" policy, effective date 12/2010, revealed the facility would implement interventions as identified on the individualized care plan to treat chronic and/or acute constipation. Continued policy review	F 280	1. The care plan for for Resident #4 was updated by Unit Manager on 4/1/2015. An audit of Resident #4s chart was completed by Unit Manager on 4/1/2015 for any diagnosis or physician order that was not captured on the care plan. 2. The Director of Nursing, Unit Manager, and MDS nurses complete a 100% audit of residents charts for physician orders and care plan updates by 4/27/15. No issues identified. 3. The Director of Nursing, Unit Manager, Staff Development Coordinator educated all licensed staff by 4/27/15 on ensuring care plans are updated with any new physician orders or change of condition. Beginning on 5/20/15, all newly hired licensed staff will receive education on updating the care plan with any new physician orders or change of condition, as a part of the orientation process by the Staff Development Coordinator, Director of Nursing or Unit Managers. New physician orders and care plans will be reviewed daily Monday through Friday in the morning stand up meeting with the Interdisciplinary team which includes but is not limited to, the Director of Nursing, Social Service Director, Unit Managers, Dietary Director and MDS Nurse to ensure care plans are updated. 4. An audit will be completed on 10 residents weekly for twelve weeks by the Director of Nursing or Unit Managers to ensure that the care plan was updated to include current physician orders and to ensure that any change of condition is addressed on the care plan. Any issues identified will be corrected immediately. Findings will be reported monthly for three months to the Quality Assurance committee, then quarterly thereafter. 5. 5/18/2015	5/18/2015	

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F 280	Continued From page 2 revealed the care plan would be revised to indicate all appropriate interventions as indicated. Review of Resident #4's clinical record revealed the facility admitted the resident on 11/08/10 with diagnoses which included Alzheimer's Disease, Psychotic Disorder, and Chronic Heart Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/20/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of a four (4) out of fifteen (15), which indicated severe cognitive impairment. Further review revealed the facility assessed Resident #4 as being totally dependent and requiring the assistance of two (2) staff for toileting. Further review revealed Resident #4 was always incontinent of bowel and bladder. Review of the Physician's Orders for February 2015 and March 2015, revealed the following: Senna Laxative 8.6 milligram (mg) tablet, once daily for a diagnosis of constipation; Milk of Magnesia, 10 milliliters (ml) daily prn (as needed) for constipation; and Bisacodyl, 10 mg suppository daily as needed for constipation. Review of the Elimination Report and the Alert Description, a computerized form which showed if the resident or staff had been interviewed and determined the resident did have a bowel movement (BM), revealed Resident #4 had a BM on 02/05/15. Further review of the Elimination Report and Alert Description, revealed no documented evidence the resident had a BM from 02/05/15 until 02/11/15, six (6) days later. Continued review revealed no documented evidence Resident #4 had a BM between 02/15/15 and 02/21/15, or between 02/25/15 and	F 280			

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F 280	Continued From page 3 03/02/15. Review of the Comprehensive Care Plan for Resident #4, dated 11/25/14, revealed it did not address the problem of constipation, acute or chronic, and did not include interventions for tracking and monitoring episodes of constipation, or specific actions to prevent and/or treat constipation when it occurred. Continued review revealed the care plan had not been or revised since 11/25/14 even though Resident #4 had three six (6) day periods with no BM in February and March. Interview with the Unit Manager for the North Unit where Resident #4 resided, on 04/02/15 at 4:00 PM, revealed she was aware Resident #4 often went more than three (3) days without a BM. She stated this could be a normal pattern for this resident; however, she further stated no resident should go over seventy-two (72) hours without a BM, and Resident #4 required close monitoring due to a history of constipation and a need for prn laxatives. Continued interview revealed Resident #4's care plan needed to be revised to reflect the resident's problem of constipation. Interview with the Director of Nursing, on 04/02/15 at 5:00 PM, revealed it was her expectation that the Bowel Regimen be followed. She stated Resident #4's care plan should be revised due to the resident's history of constipation.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309			

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F 309	<p>Continued From page 4</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure necessary care and services were provided for each resident's physical well-being, for one (1) of nineteen (19) sampled residents(Resident #4).</p> <p>The facility failed to follow their "Bowel Regimen" for Resident #4 regarding the administration of medications when the resident did not have a bowel movement (BM) for three (3) days. Furthermore, there was no documented evidence Resident #4 experienced bowel movements for three (3) six (6) day periods during February and March 2015, 02/05/15 through 02/11/15, 02/15/15 through 02/21/15, and 02/25/15 through 03/03/15.</p> <p>The findings include:</p> <p>Review of the facility's "Bowel Movement (BM) Regimen", effective December 2010, revealed the facility would monitor and track residents on a daily basis to determine the need for dietary and/or chemical intervention to treat chronic and/or acute episodes of constipation. Continued review revealed the facility would implement appropriate interventions as identified on the Resident's care plan, Physician's Orders, and /or dietary recommendations. Suggested interventions included: supply high fiber drinks and/or food</p>	F 309	<p>Harrodsburg Health and Rehabilitation Center does not believe and does not admit that any deficiencies existed before, during, or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or any other legal proceedings. This allegation of compliance is not intended to and does not establish any standard of care, contract obligation, or position, and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this allegation of compliance should be considered or relied upon as a waiver of any potentially applicable Peer Review, Quality Assurance, self-critical examination, or any other legal privileges in any administrative, civil or criminal claim, action or proceeding. The Facility offers in response, credible allegations of compliance, and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	5/18/2015
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F 309	Continued From page 5 supplements, e.g. prune juice, if the resident has no BM for three (3) days; administer a designated laxative on the evening shift of the third day; if there is no BM by the following morning, administer a suppository after breakfast; and if there is no BM by the evening of the fourth day, administer a Fleets enema. Further review of the "BM Regimen, revealed the Certified Nursing Assistants (CNA's) were to record all BMs on the CNA Assignment Sheet or specified form. The Assignment Sheet/form was to be turned in to the charge nurse at the end of the shift and the charge nurse or designated staff would record the BMs on the resident BM record located with the Medication Administration Record (MAR). Continued review revealed each charge nurse was responsible at the beginning of their shift to identify residents who had not had a BM in more than forty-eight (48) hours and implement the approved regimen for that resident. Medical interventions were to be recorded on the MAR. Review of Resident #4's medical record revealed the facility admitted the resident on 11/08/10 with diagnoses which included Alzheimer's Disease, Psychotic Disorder, and Chronic Heart Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 02/201/5, revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident was severely cognitively impaired. Further review revealed the facility assessed the resident to be totally dependent and require the assistance of two (2) staff for toileting. Continued review of the MDS revealed Resident #4 was always incontinent of bowel and bladder. Review of the Physician's Orders for February	F 309	1. The elimination report for Resident #4 for the previous week was reviewed by the Unit Manager. The bowel regimen for resident #4 was reviewed. On 4/2/2015 the bowel movement report for resident #4 was reviewed. Documentation showed resident #4 had a large bowel movement on 4/1/2015. .2. Elimination reports for the previous 72 hours were reviewed by Director of Nursing and Unit Managers on all other residents by 4/5/15. No other issues were identified. .3. All c.n.a's and nurses were re-educated by Director of Nursing, Unit Managers or Staff Development by 4/27/15 on monitoring and documenting bowel movements and ensuring all residents needs are being met and that the bowel protocol is followed. Beginning on 5/20/15, all newly hired c.n.a's and nurses will receive education on monitoring and documenting bowel movements and ensuring that all resident needs are met and that the bowel protocol is followed, by the staff development coordinator, Director of Nursing, Unit Managers as a part of the orientation process. .The Bowel Movement Exception report will be ran daily Monday through Friday and reviewed in the morning clinical meeting by the IDT, which includes but is not limited to the Director of Nursing, MDS Nurse, Staff Development Coordinator, Unit Managers and Dietary Director for all residents with no bowel movements for the previous 72 hours. Any resident identified not having a bowel movement in the past 72 hours will be started on bowel regimen per policy. 4. The Unit Managers will audit 10 residents per week for 12 weeks to ensure proper bowel regimen is being followed. Any issues identified will be addressed immediately and reported to Director of Nursing or Administrator. Any issues identified will be reported to the QA committee for three months, then quarterly thereafter. 5. 5/18/15	5/18/2015	

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F 309	<p>Continued From page 6</p> <p>2015 and March 2015 revealed the following orders: Senna Laxative, 8.6 milligram (mg) once daily for a diagnosis of constipation; Milk of Magnesia (MOM-a laxative medication) 10 milliliters (ml) daily prn (as needed) for constipation; and Bisacodyl (a laxative medication) 10 mg suppository daily prn for constipation.</p> <p>Review of the computerized Elimination Report and computerized Alert Description (a computerized form which showed if the resident or staff had been interviewed and determined the resident had a BM), revealed Resident #4 had a BM on 02/05/15. Continued review revealed no documented evidence Resident #4 had another BM from 02/05/15 until 02/11/15 (6 days), when the resident had a small BM.</p> <p>Review of the Medication Administration Record (MAR) for the month of February 2015, revealed no documented evidence Resident #4 received a prn (as needed) laxative from 02/06/15 through 02/10/15. Continued review of the MAR revealed on 02/11/15, the resident received a Bisacodyl 10 mg suppository which was effective. Review of the Nurses Notes for the same time period revealed no documented evidence of the administration of any prn laxatives, or of a BM for Resident #4.</p> <p>Further review of the MAR, revealed Resident #4 was administered MOM 10 ml on 02/15/15, and the medication was effective. However, there was no documented evidence on the Elimination Report or the Alert Description form the resident had another BM until 02/21/15 (6 days later). Further review of the February 2015 MAR revealed no documented evidence any prn</p>	F 309		
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F 309	<p>Continued From page 7</p> <p>laxatives were administered during the six (6) day period. In addition, review of the Nurses Notes revealed no documented evidence of any prn laxatives being administered, or of the resident having a BM on 02/16/15 through 02/20/15.</p> <p>Further review of the Elimination Report revealed Resident #4 had a BM on 02/25/15 which was described as small. Continued review revealed no documented evidence the resident had another BM until 03/03/15. According to the MAR, dated March 2015, MOM 10 ml prn was administered on 03/03/15 which was effective. Review of the Nurses Notes for 02/26/15 through 03/02/15 revealed no documented evidence of a BM during this time span.</p> <p>Interview with the Unit Manager for the North Unit where Resident #4 resided, on 04/21/15 at 4:00 PM, revealed the nurses were to check the computer each shift for an "alert" which indicated the resident had not had a BM for 72 hours. She stated if the resident had no BM in 72 hours, a bowel assessment was to be done and the nurse was to administer prune juice or a prn laxative. She further stated a resident should not go over seventy-two (72) hours without a BM. The Unit Manager reviewed Resident #4's medical record and acknowledged the resident had three (3) different episodes without a BM for six days in February and March 2015, and the nurse should have administered a prn laxative for the resident in each instance. Continued interview revealed Resident #4 had constipation and the Bowel Regimen was not followed.</p> <p>Interview with the Director of Nursing, on 04/02/15 at 5:00 PM, revealed it was her expectation for the Bowel Regimen to be</p>	F 309		
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F 309	Continued From page 8 followed.	F 309		5/18/2015	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 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 maintain an environment free from accident hazards as evidenced by hot water temperatures above the acceptable range in the facility's South Unit. Temperatures obtained during the initial facility tour revealed hot water temperatures above 110 degrees Farenheit (F) in the South Unit Shower Room and in sinks in resident rooms on South Unit. The findings include: Review of Mechanical Requirement 902 KAR 20:310-16 (5)(g) revealed plumbing fixtures which required hot water intended for patient use were controlled to provide a maximum water temperature of 110 degrees F at the fixture. Record Review of the facility's Water Temperatures Policy, dated January 2005, revealed hot water temperatures were maintained	F 323	Harrodsburg Health and Rehabilitation Center does not believe and does not admit that any deficiencies existed before, during, or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or any other legal proceedings. This allegation of compliance is not intended to and does not establish any standard of care, contract obligation, or position, and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this allegation of compliance should be considered or relied upon as a waiver of any potentially applicable Peer Review, Quality Assurance, self-critical examination, or any other legal privileges in any administrative, civil or criminal claim, action or proceeding. The Facility offers in response, credible allegations of compliance, and plan of correction as part of its ongoing efforts to provide quality of care to residents.		

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F 323	<p>Continued From page 9 within the state's acceptable range. Further review of the policy revealed water temperatures were spot checked weekly and logged in the logbook.</p> <p>Observation of hot water temperatures with the Maintenance Supervisor (MS), on 03/31/15 between 10:40 AM and 11:12 AM, revealed hot water temperatures above 110 degrees Fahrenheit (F) in the following resident room sinks: 118.2 degrees F in room 402; 113.2 degrees F in room 400; 118.2 degrees F in room 314; 121.1 degrees F in room 312; 112.8 degrees in room 305; and 120.4 degrees F in room 307. In addition, the hot water temperature in the South Shower room was 113.9 degrees F.</p> <p>Interview with the MS, on 03/31/15 at 10:40 AM and 11:16 AM, revealed the facility tried to keep hot water temperatures between 100 and 110 degrees F. He stated resident room water temperatures were checked weekly on each hall, and shower room water temperatures were checked "periodically".</p> <p>Record Review of the facility's Water Temperature Log revealed weekly water temperature checks in resident rooms, with no documented temperatures greater than 110 degrees F. Continued review revealed the shower room hot water temperature was last logged on 12/05/15 and was within the acceptable range at that time.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1, on 03/31/15 at 11:39 AM, revealed the sink hot water temperature in room 314 (118.2 degrees F) felt a little hot.</p>	F 323	<p>1. On 3/31/2015 the Maintenance Director adjusted the mixing valve which services resident rooms #314, #402, # 312, #305, #307 and #400 and the shower room on the South Wing. Water temperatures in affected areas were checked every 15 minutes until temperatures were within regulatory ranges. Showers were stopped immediately on South Wing.</p> <p>2. Skin assessments were completed on all residents on the South Wing to ensure no injury occurred. No issues were identified. Water temperatures were checked by the maintenance director on 3/31/15 throughout the facility. No other issues identified.</p> <p>3. The Director of Nursing, Administrator, Staff Development Coordinator, or Maintenance Director educated all staff regarding the potential for injury due to increased water temperatures. C.N.A's and nurses were educated on procedure for testing water temperatures prior to giving showers or baths. This included education on the notification process if increased water temperatures were identified which included to place an out of order sign on the affected sink and immediately notify charge nurse and maintenance director. All newly hired staff will be educated by the maintenance director or staff development coordinator as a part of the orientation process on always checking the water temps (to touch) prior to providing showers and as they are washing their hands. If the water seems to hot or to cold, to follow the procedure of placing an out of order sign on the sink and immediately notifying the charge nurse and maintenance director.</p> <p>4. The Maintenance Director, Maintenance Assistant will check water temperatures in ten resident rooms and shower rooms daily for one week. The Maintenance Director, Maintenance Assistant, will then check water temperatures in ten resident rooms throughout the facility and shower rooms weekly for 12 weeks. Any issues identified will be corrected immediately. Any issues identified will be reported to the QA committee monthly for three months, then quarterly thereafter.</p>	5/18/2015
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F 323	<p>Continued From page 10</p> <p>Interview with Registered Nurse (RN) #1 and Licensend Practical Nurse (LPN) #1, on 03/31/15 at 11:35 AM, revealed the hot water in room 312 (121.1 degrees F) was very warm and was too hot for the resident.</p> <p>Interview, on 03/31/15 at 11:57 AM, with the Staff Development Coordinator/LPN #2 revealed she was on the facility's Safety Committee and they routinely discussed water temperatures at the meeting. She revealed the hot water temperature goal was between 100-110 degrees F. She further revealed staff were informed if the water temperature in resident rooms was too hot, they were to fill out a work order and page Maintenance to the room.</p> <p>Interview with the Director of Nursing (DON), on 03/31/15 at 12: 01 PM, revealed she was not familiar with the hot water regulation. She stated it was a concerning for potential burns if the hot water temperature was above the regulation guideline.</p> <p>Interview with the Administrator, on 04/02/15 at 5:01 PM, revealed hot water temperatures were supposed to be between 100-110 degrees F. She stated the identified hot water temperatures above the acceptable range were a concern because of the potential for resident burns. She further stated the facility randomly checked and logged water temperatures weekly and had not identified a concern prior to State Agency findings. Continued interview revealed staff were to notify the Maintenance Department if they had hot water concerns but no reports had been made. Further interview revealed the facility had taken steps to correct the problem and protect the residents, and would be monitoring the water</p>	F 323	5. 5/18/15	

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F 323	Continued From page 11 temperatures more frequently. F 333 483.25(m)(2) RESIDENTS FREE OF SS=D SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. 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 each resident was free of any significant medication errors, for one (1) of eleven (11) sampled residents (Resident #9) who were reviewed for medication errors, out of a total sample of nineteen (19) residents. Physician's Orders were written for Resident #9 on 02/08/15 for Abilify 5 milligrams (mg) to be administered twice daily. Abilify is an antipsychotic medication which is also used in conjunction with other medications to treat Major Depressive Disorder. However, the resident received Abilify 10 mg twice a day from 02/09/15 through 04/01/14 (52 days), and the error was not identified until surveyor intervention. The findings include: Review of the facility's "Physician's Orders at a Glance" policy, undated, revealed when a Physician or other practitioner gave an order in writing, by telephone or fax, or written directly in the resident's chart, the chart was flagged to identify a new order, and the nurse receiving the	F 323 F 333	Harrodsburg Health and Rehabilitation Center does not believe and does not admit that any deficiencies existed before, during, or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or any other legal proceedings. This allegation of compliance is not intended to and does not establish any standard of care, contract obligation, or position, and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this allegation of compliance should be considered or relied upon as a waiver of any potentially applicable Peer Review, Quality Assurance, self-critical examination, or any other legal privileges in any administrative, civil or criminal claim, action or proceeding. The Facility offers in response, credible allegations of compliance, and plan of correction as part of its ongoing efforts to provide quality of care to residents. 5/18/2015

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F 333	<p>Continued From page 12</p> <p>order was responsible for completing order documentation, and communicating with the pharmacy. Continued review revealed the nurse was to transcribe medication orders to the Medication Administration Record (MAR), to include the correct medication, dosage, and the frequency and route of administration. Furthermore, the nurse was to fax the new medication order to the pharmacy, and the call pharmacy if the order was needed immediately or if the order was received after hours. Copies of the order were to be provided to the Director of Nursing (DON), Assistant Director of Nursing (ADON), and medical records, and the original was to stay in the chart. Further review revealed new orders were reviewed and checked for accuracy at the daily clinical meetings.</p> <p>Review of Resident #9's medical record revealed diagnoses which included Depression and Cirrhosis of the Liver. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/18/15, revealed the facility assessed Resident #9 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), which indicated the resident was cognitively intact.</p> <p>Review of the Comprehensive Plan of Care for Resident #9, dated 11/25/15, revealed the problem of psychotropic medication use, with the stated goal to ensure the resident received the least dosage prescribed to ensure maximum physical and mental functional ability.</p> <p>Review of the Physician's Orders dated 02/08/15, handwritten by the Attending Physician, revealed an order for Abilify, 5 mg twice daily for a diagnosis of depression. Further review of the</p>	F 333	<p>1. Resident #9 orders were clarified on 4/2/2015 and medications were initiated as ordered.</p> <p>2. An audit was completed by 4/13/15 by the Director of Nursing, MDS Nurse or Unit Managers to ensure that the MAR/TAR was accurate when compared to physician orders. No other concerns were identified.</p> <p>3. Resident charts will be checked daily, Monday through Friday by the Director of Nursing or Unit Managers as a part of the clinical meeting for any new orders to ensure orders are transcribed on the MAR/TAR and administered accordingly. Licensed staff will be in-serviced by Pharmacy, Staff Development Coordinator, Director of Nursing or Unit Managers on proper policy and procedure of medication administration, ordering and receiving of medications and transcription by 4/27/15.</p> <p>Beginning on 5/20/15, all newly hired licensed staff will receive education on updating the care plan with any new physician orders or change of condition as a part of the orientation process.</p> <p>4. The Director of Nursing, Unit Managers or MDS Nurse will audit 10 charts per week for 12 weeks to ensure that the MAR/TAR matches the current physician orders. Findings of the above stated audits will be reviewed by the QA committee monthly for three months for recommendations and further follow-up as indicated.</p> <p>5. 5-18-15</p> <p>5/18/2015</p>

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F 333	<p>Continued From page 13</p> <p>order revealed 10 mg had been written, with a 5 written on top of the 10 in darker ink.</p> <p>Review of Resident #9's MAR for February 2015 revealed Abilify 10 mg BID (twice a day) had been transcribed to the MAR. Continued review of the MARs for March and April 2015 revealed Abilify 10 mg was administered BID starting on 02/09/15 through 04/01/15. Further review of the MAR for April 2015 revealed Resident #9 received the morning dose of Abilify 10 mg on 04/02/15.</p> <p>Review of the Monthly Physician's Orders dated March 2015 and April 2015, revealed the resident was ordered Abilify 10 mg BID. However, there was no order to increase the Abilify to 10 mg BID after the original order was written on 02/08/15 for Abilify 5 mg BID.</p> <p>Review of the Attending Physician's Progress Note, dated 02/08/15, revealed the plan to increase Resident #9's Abilify to 5 mg BID for mood.</p> <p>Review of the Psychiatric Evaluation, dated 02/18/15, revealed the resident was receiving psychiatric medications including: Celexa (antidepressant medication) 40 mg every day; Ambien (Hypnotic medication) 5 mg every night; Ritalin (central nervous system stimulant medication) 10 mg in the morning and at noon; Remeron (antidepressant medication) 15 mg at night; and Abilify 5 mg BID. Continued review revealed staff had reported since medication changes of increasing the Ritalin, and adding Abilify and Remeron, the resident had become more irritable and argumentative. Further review revealed a recommendation was made to decrease the Ritalin to 10 mg in the morning, and</p>	F 333	

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F 333	<p>Continued From page 14</p> <p>5 mg at noon. There was no indication the Psychiatrist was aware the resident was receiving Abilify 10 mg BID instead of 5 mg BID.</p> <p>Review of the Medication Regimen Review, completed by the Consulting Pharmacist on 03/25/15, revealed Resident #9 was receiving psychoactive medications including Abilify 5 mg BID, Remeron 15 mg at night, Ritalin 10 mg BID, Ambien 5 mg at night, and Celexa 40 mg daily. Continued review revealed no indication the Consulting Pharmacist was aware the resident was receiving Abilify 10 mg BID instead of 5 mg.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 04/02/15 at 1:30 PM, and observation of the medication drawer for Resident #9, revealed a supply of Abilify 10 mg tablets which were issued by the Pharmacy on 02/09/15. LPN #3 stated Resident #9 was receiving Abilify 10 mg BID.</p> <p>Interview with the South Unit Manager, on 04/02/15 at 2:00 PM, revealed the Attending Physician wrote the order himself for Abilify on 02/08/15 and LPN #4 signed the order off meaning he transcribed the order to the computer. She stated the process for taking off Physician's Orders was to input the order into the computer by typing the order under "Physician's Orders". She further stated this would download automatically to the pharmacy. Continued interview revealed LPN #4 stated it looked like originally 10 mg was written, then 5 was written on top of the 10.</p> <p>Phone interview with the Attending Physician, on 04/02/15 at 2:15 PM, revealed he would need to see his Progress Note in order to see what dosage of medication he had intended to write on</p>	F 333			

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F 333	<p>Continued From page 15</p> <p>02/08/15. He stated he had not received any report of Resident #9 having an adverse side effect of his/her psychotropic medications.</p> <p>Phone interview with the Consulting Pharmacist, on 04/02/15 at 2:30 PM, revealed it could be a significant medication error if Resident #9 was receiving Abilify 10 mg BID instead of 5 mg BID, because the medication could cause a movement disorder and sedation. She stated she should have caught the error during her Drug Regimen Review which she completed on 03/25/15.</p> <p>Phone interview with LPN #4, on 04/02/15 at 2:40 PM, revealed he had received training related to inputting Physician's Orders into the computer. He stated once he received the order, he went to the "Physician's Orders" section of the computer program and typed it in. He further stated the order was automatically uploaded to the pharmacy. Continued interview revealed he remembered the Attending Physician wrote Abilify 10 mg BID and he typed the order into the computer. He reported he then noted the Attending Physician had written 5 mg on top of the 10 mg, and stated he had put a clarification into the computer.</p> <p>Interview with the Director of Nursing (DON), on 04/02/15 at 5:00 PM, revealed once a Physician's Order was entered into the computer and the medication had been administered even once, the nurse could not put a clarification for that order into the computer. She stated the nurse would have to discontinue the order and place a new Physician's Order. Further interview revealed all nurses had been trained on entering Physician's Orders into the computer; however, the DON was unsure if they were aware they</p>	F 333			

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F 333	Continued From page 16 could not clarify an order in the computer if the medication had been administered at least once. Continued interview revealed the error should have been caught during the monthly change-over of orders. She explained the process for the monthly change-overs was for the nurse to compare the previous monthly orders with the new monthly orders, and review all phone orders or hand-written orders received since the previous month to check for discrepancies. The DON further stated the Physician's Orders came in three (3) parts and one (1) copy went to the daily morning meeting (Monday through Friday) and the phone orders were checked against the computer system at that time. However, she stated if the nurse had pulled a copy of the original order for 10 mg BID before it was written over and changed to 5 mg BID, they would have had the wrong copy of the order to check for accuracy. The DON stated they were all still learning the computer system, and the nurses may need more education.	F 333	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428	

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F 428	<p>Continued From page 17</p> <p>by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure the Pharmacist identified irregularities and made recommendations to correct the regulators during the Medication Regimen Review (MRR), for one (1) of eleven (11) sampled residents (Resident #9) who were reviewed for medication errors out of a total sample of nineteen (19) residents.</p> <p>According to the Physician's Order dated 02/08/15, Resident #9 was to receive Abilify (an antipsychotic medication which is also used in conjunction with other medications to treat Major Depressive Disorder) 5 milligrams (mg) twice daily (BID); however, the resident received Abilify 10 mg BID from 02/09/15 through 04/01/14 (52 days). The error was not identified by the Consulting Pharmacist on the Drug Regimen Review completed on 03/25/15.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Medication Regimen Review and Reporting", dated 2007, revealed the Medication Regimen Review (MRR) was defined as the systematic evaluation of medication therapy. Continued review revealed the Consultant Pharmacist was to review the medication regimen of each resident at least monthly, and the findings and recommendations were to be communicated to those with authority to implement the recommendations, including the Administrator, Director of Nursing (DON), the Attending Physician and/or the Medical Director. Resident specific MRR findings and recommendations were to be documented and acted upon by the facility and/or the Physician.</p>	F 428	<p>Harrodsburg Health and Rehabilitation Center does not believe and does not admit that any deficiencies existed before, during, or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or any other legal proceedings. This allegation of compliance is not intended to and does not establish any standard of care, contract obligation, or position, and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this allegation of compliance should be considered or relied upon as a waiver of any potentially applicable Peer Review, Quality Assurance, self-critical examination, or any other legal privileges in any administrative, civil or criminal claim, action or proceeding. The Facility offers in response, credible allegations of compliance, and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	5/18/2015	

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F 428	<p>Continued From page 18</p> <p>Further review revealed the Consulting Pharmacist and the facility were responsible for follow-up on the recommendations to verify appropriate actions were taken within a reasonable time frame.</p> <p>Review of Resident #9's clinical record revealed diagnoses which included Depression and Cirrhosis of the Liver. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/18/15, revealed the facility assessed Resident #9 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), indicating the resident was cognitively intact.</p> <p>Review of Resident #9's Physician's Orders, dated 02/08/15 and handwritten by the Attending Physician, revealed an order for Abilify 5 mg twice a day, related to a diagnosis of Depression. Further review revealed 10 mg was originally written, with a five (5) written on top of the ten (10) in darker ink.</p> <p>Review of Resident #9's MAR for February 2015 revealed Abilify 10 mg BID was printed on the MAR for scheduled administration. Continue review revealed the medication was administered BID beginning on 02/09/15, and continued through 02/28/14. Review of the MAR for March and April 2015, revealed Abilify 10 mg continued to be administered twice a day through 04/01/15. Furthermore, the morning dose of Abilify 10 mg was administered on 04/02/15.</p> <p>Review of the Monthly Physician's Orders dated March 2015 and April 2015, revealed Resident #9 was to receive Abilify 10 mg. BID. Continue review revealed Abilify 5 mg was originally ordered on 02/08/15. Further review no order was ever</p>	F 428	<ol style="list-style-type: none"> 1. Resident #9 orders were clarified on 4/2/2015 and medications were initiated as ordered. 2. On 4/13/2015 the pharmacist completed a 100% audit on orders from 2/1/2015 to current to ensure no medication errors were identified. No other issues were identified. 3. The Unit Managers or Director of Nursing educated all licensed staff on proper procedure for transcription from physician orders to EZ- MAR by 4/27/15. Beginning on 5/20/15, all newly hired licensed staff will receive education on updating the care plan with any new physician orders or change of condition as a part of the orientation process. 4. The Director of Nursing, Unit Managers or MDS Nurse will audit 10 charts per week for 12 weeks to ensure that the MAR/TAR matches the current physician orders. The Unit Manager, Director of Nursing, or MDS nurses will reconcile physician orders to the Medication Administration Record monthly on a continual basis. Any issues identified will be corrected immediately and reported to the QA committee monthly for three weeks, then quarterly thereafter. 5. 5/18/15 	5/18/2015	

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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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)
F 428	<p>Continued From page 19</p> <p>received to Abilify to 10 mg after the original order was written.</p> <p>Review of the Psychiatric Evaluation, dated 02/18/15, revealed Resident #9 was receiving multiple psychiatric medications, including Abilify 5 mg BID. Continued review revealed staff reported Resident #9 had become more irritable and argumentative. Further review revealed no indication the Psychiatrist was aware the resident was receiving Abilify 10 mg BID.</p> <p>Review of the MRR, signed by the Consulting Pharmacist on 03/25/15, revealed Resident #9 was receiving psychoactive medications including Abilify 5 mg BID. Continued review revealed no documented evidence the Consulting Pharmacist was aware the resident was actually receiving Abilify 10 mg BID.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, and observation of Resident #9's medication drawer on 04/02/15 at 1:30 PM, revealed the presence of Abilify 10 mg tablets which were issued by the Pharmacy on 02/09/15. LPN #3 stated Resident #9 was receiving Abilify 10 mg BID.</p> <p>Phone interview with the Consulting Pharmacist, on 04/02/15 at 2:30 PM, revealed overmedicating Resident #9 with Abilify could be significant, especially if the resident exhibited signs and symptoms. She explained when she completed an MRR, she reviewed the medications and compared them to the Monthly Physician's Orders, telephone orders received since the last review, and the MARs. The Consulting Pharmacist stated she should have caught the error during the MRR which she completed on</p>	F 428	

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

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/03/2015
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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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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 428	<p>Continued From page 20 03/25/15.</p> <p>Interview with the Director of Nursing (DON), on 04/02/15 at 5:00 PM, revealed the medication error could have been due to incorrect entry into the computer by the transcribing nurse. She stated the change from ten (10) to five (5) on the original order may have been a contributing factor in the error. However, she further stated the error should have been caught during the MRR completed by the Pharmacist on 03/25/15. Continued interview revealed it was her expectation for the Consulting Pharmacist to review the medications monthly, identify discrepancies, and make recommendations based on his/her findings.</p>	F 428		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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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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K 000	INITIAL COMMENTS CFR : 42 CFR 483.70(a) Building: 01 Plan Approval: 12/01/75 SURVEY UNDER: NFPA 101 (2000 Edition) FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) Story, Type V (000) Unprotected SMOKE COMPARTMENTS: Five (5) COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (original installed) FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) updated 2005 EMERGENCY POWER: Type II Diesel installed in 2000 A Life Safety Code Survey was initiated and concluded on 04/02/15. The facility was in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility is licensed for one hundred twelve (112) beds with a census of ninety-five (95) on the day of the survey.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Pamela Upsten* TITLE Administrator (X6) DATE 5-18-15

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.