

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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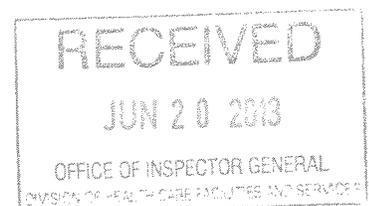
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F 241	<p>Continued From page 2</p> <p>AM, revealed the resident sitting at a table in the common area/dining room on the locked unit. The resident was served a cup of coffee which was rejected by the resident. The Activity Assistant took the coffee and placed it on a cart. She was looking at the CNA quizzically. The CNA said you fixed that especially for him/her and he/she did not want your coffee. The activity assistant shrugged her shoulders and the CNA said the resident would not eat the oatmeal at breakfast either. Both laughed, shook their heads and looked at the resident. Resident #9 did not say anything and just bowed his/her head. There were ten (10) other residents in the room.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident with diagnoses of Bipolar Disorder, Paranoid Schizophrenia and Dementia. The facility completed a significant change Minimum Data Set (MDS) assessment on 04/18/13 which revealed the resident had severe cognitive impairments.</p> <p>Interview with the Activity Assistant, on 05/22/13 at 11:50 AM, revealed it was inappropriate for her and the CNA to be discussing Resident #9 in the dining room. She stated she had received training on dignity of residents. She stated seeing an incontinence pad on a resident's bed indicated that the resident was incontinent and visitors or other residents should not have that information. In addition, posting resident information on a bulletin board available to other residents and visitors was also inappropriate.</p> <p>Interview with CNA #3, on 05/22/13 at 11:55 AM, revealed she did not think her voice was loud</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>least once weekly by the Director of Nursing to validate timely assistance provided to residents according to their plan of care.</p> <p>IV. How the facility plans to monitor its performance to make sure solutions are sustained: The Unit Manager and Director of Nursing Services weekly audits will be track and trend with results reported to the Performance Improvement Committee monthly for the next 6 months or until sustained compliance is achieved.</p>	July 6, 2013

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FORM APPROVED
OMB NO. 0938-0391

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F 241	<p>Continued From page 3</p> <p>enough for the residents to hear her remarks regarding Resident #9. She stated she should not have talked about the resident in front of the resident and the other residents in the dining room. She stated she did place the incontinent pads on top of Resident #9's made bed in case the resident was incontinent while napping. She revealed she did not think about how it would look to others and stated it was inappropriate. She stated she had received training on resident dignity.</p> <p>Interview with the Program Director, on 05/22/13 at 11:58 AM, revealed the common area/dining room was so small that remarks could be heard by all in the room; however, the staff should not have talked about Resident #9 in front of the resident and all the other residents present. She stated she did not know the posted information on Residents #9, #B and #C was a dignity issue. In addition, she stated the incontinence pad on Resident #9's bed did signify the resident was incontinent and that was a dignity concern. She stated all staff had in-service training regarding dignity.</p> <p>Interviews with Resident #9, on 05/22/13 at 12:15 PM and 1:30 PM, were unsuccessful. The resident would not respond to conversation regarding the incident.</p> <p>Interview with Resident #10, on 05/22/13 at 12:40 PM, revealed staff were kind and the resident had no memory of the incident.</p> <p>Interview with the Director of Nursing, on 05/22/13 at 1:00 PM, revealed her expectations were for residents to be treated respectfully by</p>	F 241		



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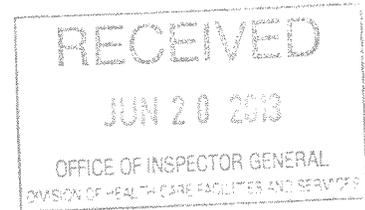
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F 241	<p>Continued From page 4</p> <p>staff and staff were trained to provide dignity and respect.</p> <p>2. Observation of the dinner meal for dependent residents, on 05/21/13 at 5:55 PM, revealed Resident #15 and Unsampled Resident A seated at a table in the main dining room with two (2) other residents. All four (4) of the residents had been served their meals. The two (2) other residents proceeded to eat their meals with Resident #15 and Unsampled Resident A watching them, but Resident #15 and Unsampled Resident A made no effort to feed themselves. There were two (2) staff observed assisting residents with their meals while all of the trays had been served to a total of thirty (30) residents in the room. Resident #15 was observed to be seated and watching the two residents eat for twenty (20) minutes and Unsampled Resident A was observed to be seated and watching the two residents eat for twenty-five (25) minutes before either was assisted with eating. After a time lapse of twenty (20) minutes, the Director of Nursing, the Dietician, the facility Nurse Practitioner and one other Certified Nursing Assistant entered the dining room and two (2) of them proceeded to assist Resident #15 and Unsampled Resident A with eating.</p> <p>Interview with CNA #6, on 05/23/13 at 9:10 AM, revealed she had worked at the facility for six (6) months and she had been trained to assist residents with eating by verbally prompting, hand over hand or complete assistance with eating. She stated she was assigned on a shift assignment sheet if she was to assist with dining and the staff assigned to the dining room to assist resident's with their meals knew which residents</p>	F 241		
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F 241	<p>Continued From page 5</p> <p>needed assistance by the CNA care plans. CNA #6 revealed there was no one in the dining room to assign particular residents to staff, but they just knew who to help and talked with each other to determine which residents to assist with their meals.</p> <p>Interview with LPN #2, on 05/23/13 at 9:20 AM, revealed she was on the schedule to monitor the dining room at dinnertime on 05/21/13, but was reassigned that evening to pass medications. She stated she did not ensure someone else was monitoring the dining room because the DON had reassigned her and she assumed the DON would ensure someone else would do the monitoring. She further revealed three (3) CNA's were assigned from her unit to assist in the dining room but only one (1) was able to go due to needs on the unit.</p> <p>Interview with the Dietician, on 05/23/13 at 9:30 AM, revealed she worked at the facility three (3) days a week and she monitored a meal on one of those days. She stated she noticed there were not enough CNA's in the dining room for the dinner meal on 05/21/13 and sought the help of the DON, the facility Nurse Practitioner and a CNA to go to the dining room and assist residents with eating. She further stated food served twenty (20) to twenty-five (25) minutes prior to giving residents assistance with eating would be cold and it was not respectful or maintained resident dignity to have their trays in front of them with no assistance with eating for that length of time.</p> <p>Interview with the DON, on 05/23/13 at 2:00 PM, revealed the facility had an assigned person to</p>	F 241		
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F 241	<p>Continued From page 6</p> <p>monitor each mealtime but on 05/21/13 there was a delay in the dinnertime meal monitoring due to the reassignment of the mealtime monitor. She stated the dining room monitor completed a form attesting their monitoring of each meal and there had not been a concern with residents in the dependent dining not being assisted with their meals. She further stated the residents who needed assistance with dining should not have to eat cold food. The DON stated it was not respectful to the residents to make them wait for dining assistance and it did not maintain their dignity.</p> <p>3. Review of Resident #16's clinical record revealed the facility admitted the resident on 09/08/11 with diagnoses of Dementia, Dysphagia (difficulty swallowing), and a stroke. The comprehensive assessment utilizing the Minimum Data Set (MDS), Dated 08/16/12, revealed the resident was limited in making themselves understood, required a one person physical assist with eating, and had one sided upper extremity impairment. The Registered Dietician completed the resident's Medical Nutrition Therapy Review, on 04/29/13, which revealed the resident was totally dependent with dining skills. The Medical Nutrition Therapy Review, dated 05/17/13, did not assess the resident's dining skills and the MDS signed 05/18/13 had the resident listed requiring set up help only for dining. Review of the resident's comprehensive plan of care revealed the resident should have as needed assistance with dining and should attend the Dependant Dining session.</p> <p>Observation of the evening meal service in the main dining room, on 05/21/13 at 5:10 PM, revealed three (3) staff members were passing</p>	F 241			

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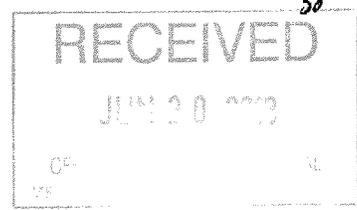
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F 241	<p>Continued From page 7</p> <p>out meal trays. Resident #16 was seated at a table by themselves facing the back wall away from the other residents. When Resident #16 was served his/her meal, two (2) cups were placed just out of the resident's reach. In addition, while attempting to feed his/her self Resident #16 continually dropped spoonfuls of the meal onto their shirt leaving the resident covered in food. After thirty (30) minutes of no assistance and surveyor intervention CNA #7 went and sat with the resident, moved the cups within the residents reach and offered cueing and assistance to the resident.</p> <p>Observation of the breakfast meal, on 05/23/13 at 7:00 AM, revealed Resident #16's three (3) cups were placed out of the residents reach. Resident #16 was observed trying to reach the thickened liquid in the cups without success and spilling food on themselves. No facility staff member was observed offering assistance to the resident.</p> <p>Interview with CNA #7, on 05/23/13 at 3:05 PM, revealed there was not enough help in the dining room for the evening meal on 05/21/13. The CNA revealed the resident should not have been placed alone at a table, and stated the resident usually sits with a friend which was also a resident. The CNA revealed the resident did not like being helped, but stated the resident had worsened and needed more guidance. The CNA revealed the cups were placed to far away and the resident was not able to reach them.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/23/13 at 4:00 PM revealed she was the Unit Manager for the Twin Spires Crossing Unit. The LPN revealed Resident #16 was not sitting in</p>	F 241		
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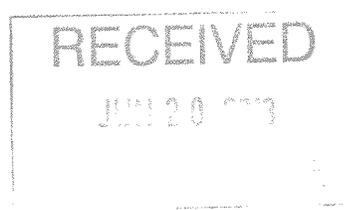
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F 253	<p>Continued From page 9</p> <p>PM, revealed the door frame leading to the common area on the locked unit with nicks and chipped paint.</p> <p>Observation of the facility, on 05/22/13 at 12:20 PM, revealed two (2) doors leading to the kitchen. The floor under the doors and the doors themselves were heavily soiled with built-up dirt and debris. The edges of the dining room floor were soiled with built-up grime.</p> <p>Observation of the facility, on 05/23/13 at 9:30 AM, revealed the floors in the doorways to Rooms 102, 107, 110, 111, 112, 115, 118, 201, 202, 212, 217, 302, 303, 304, 310, 312, 314, 317 and 319 were soiled with a dirty build-up. The hallway edges around the 100, 200 and 300 nursing stations were soiled with a build-up of dirt. Blue paint on the hallways throughout the facility were scuffed and soiled. The floor in Room 303 was heavily soiled with drips, scuffs and dried substances. Numerous door frames were chipped and soiled.</p> <p>Interview with the Housekeeping Director, on 05/23/13 at 1:30 PM, revealed the floors and doorways were soiled and needed to be stripped and cleaned. He stated the facility did not appear home-like. He stated he was supervised by the Administrator.</p> <p>Interview with the Administrator, on 05/23/13 at 2:30 PM, revealed he was responsible for ensuring the facility was clean. He stated the facility was not clean; however, he did expect the facility to be clean.</p>	F 253	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>complete painting that is needed.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction: Heath Services Group supervisor and Maintenance supervisor will conduct a weekly environmental walking round with Administrator to identify areas that need touch up painting or cleaning of any build up of dirt. Any identified concerns will be corrected immediately. Maintenance Supervisor will designate one day a week where spot painting is done the entire day. Health Service Group Supervisor and their regional manager and director will conduct weekly walking rounds validating proper cleaning performance and no build up of dirt concerns. The Administrator will be informed of the findings and approve plans for corrective actions and timeline for completion.</p> <p>IV. How the Facility plans to Monitor its performance to make sure the solutions are sustained: The results of the weekly environmental rounds with the Administrator, Health Services Group supervisor and Maintenance Supervisor will be tracked and trended with findings reported by the Administrator to the facility</p>	<p>July 6,2013</p> <p>July 6,2013</p>
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		



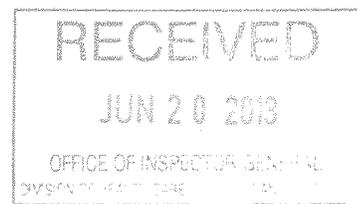
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F 279	<p>Continued From page 10</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to develop a comprehensive plan of care based on the comprehensive assessments for four (4) of the twenty-three (23) sampled and four (4) unsampled residents (Resident's # 2,9,10, and 19). The facility staff failed develop a care plan for care of an indwelling supra pubic catheter for Resident #2. The facility staff failed to develop a care plan to address interventions related to behaviors for Resident #9. The facility staff failed to develop a care plan to address the behaviors of Resident #10 and Resident #19 as</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>with further education and/or actions taken as needed. The PI Committee will monitor monthly for the next six months or until improvements are sustained.</p>	



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F 279	Continued From page 10 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to develop a comprehensive plan of care based on the comprehensive assessments for four (4) of the twenty-three (23) sampled and four (4) unsampled residents (Resident's # 2,9,10, and 19). The facility staff failed develop a care plan for care of an indwelling supra pubic catheter for Resident #2. The facility staff failed to develop a care plan to address interventions related to behaviors for Resident #9. The facility staff failed to develop a care plan to address the behaviors of Resident #10 and Resident #19 as	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>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.</i> III. What measures will be put in place/systemic changes made to ensure correction: All licensed nurses and the IDT are being educated on developing and updating residents' care plans by the Director of Nursing. This education will be completed by 7/5/13. During scheduled care plan meetings the IDT will meet and review and update care plans as needed. The IDT will review 24 hour reports and MD orders daily (M-F) at the clinical meeting and validate care plans updated as needed at that time. The Weekend Supervisor will be responsible for this review on Sat-Sun. The Director of Nursing will complete a comprehensive care plan audit each week on at least 2 residents per unit validating care plans include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment and that the care plans describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Any identified concerns will be corrected at that time.	July 6, 2013	

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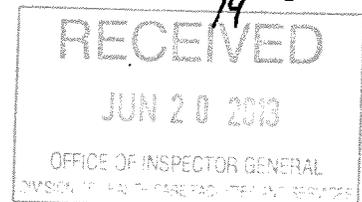
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F 279	<p>Continued From page 11 well as psychotropic medications.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, dated 01/07/13, revealed a plan of care was developed on the resident's individual needs as identified by assessments. The care plan included a treatment plan, resident preference, resident goals that are measurable and contained a schedule to evaluate the patient's progress or lack of progress toward his/her goals. The comprehensive care plan would be developed within 7 days after the completion of the comprehensive assessment [Minimum Data Set (MDS) and Care Area Assessment (CAA)] by an interdisciplinary team and included the resident, resident's family, or resident's legal representative.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 10/24/12, with diagnoses of Paraplegia, Neurogenic Bladder with an Indwelling Suprapubic Urinary Catheter, and a Pressure Sore. The facility completed a comprehensive assessment, dated 03/09/13, utilizing the MDS which identified the resident as having an indwelling urinary catheter. Review of the CAA worksheet revealed the catheter was an actual problem and would be care planned.</p> <p>Observation of Resident #2, on 05/21/13 at 3:06 PM, 05/22/13 at 8:15 AM, 9:50 AM, 11:00 AM, 12:30 PM, 2:30 PM, and 05/23/13 at 9:15 AM, revealed the supra pubic catheter was connected to a urinary drainage bag placed below the level of the bladder.</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>IV. How the facility plans to monitor its performance to make sure the solutions are sustained: The results of the care plan audits will be tracked and trended and reported monthly by the DNS to the Performance Improvement Committee with follow up actions or education as needed for the next 6 months or until compliance is achieved and sustained.</p>	July 6, 2013



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2013
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F 279	Continued From page 12 Review of the Resident's comprehensive plan of care revealed there was no plan to direct the care of the resident's urinary catheter. Interview with Registered Nurse (RN) #1, on 05/23/13 at 2:40 PM, revealed the purpose of the care plan was to make sure an action plan was established for what to do, with a measurable goal. The RN revealed he was not aware the catheter was not care planned and stated he did not use the care plans and had never actually seen the resident's plan of care. The RN revealed the resident had always had a catheter. Interview with the Mint Julip Unit Manager (UM), on 05/22/13 at 2:45 PM, revealed nursing was responsible to ensure the resident had a comprehensive plan of care, ensure actions are being followed, and revised if not working. The UM revealed Resident #2 did need a plan of care for the urinary catheter and was not aware it was not done. The UM revealed this should have been caught during weekly care plan meetings. The UM revealed she had not been attending the weekly care plan meetings as she had just been notified two (2) weeks ago she should attend. Interview with the MDS Coordinator, on 05/22/13 at 2:55 PM, revealed care plans are developed after a comprehensive assessment was completed. The MDS Coordinator revealed care plan meetings are held quarterly at which time the interdisciplinary team looked at orders, any changes, any concerns, and review the resident's comprehensive plan of care. The MDS Coordinator revealed the interdisciplinary team should have caught the absence of a plan of care	F 279			



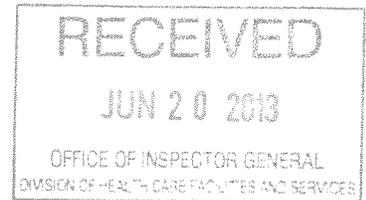
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F 279	<p>Continued From page 13 for the resident's catheter.</p> <p>Interview with the Director of Nursing (DON), on 05/23/13 at 3:30 PM, revealed Resident #2's catheter was on the old plan of care and did not know why it was not transferred over for review and continued care. The DON revealed the MDS staff was responsible to ensure all CAA triggers are addressed. The DON revealed there was no system in place to monitor care plans.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident with diagnoses of Paranoid Schizophrenia, Bipolar Disorder, Dementia and Hypertension. The facility completed a significant change MDS on 04/18/13 which revealed the resident had a severe cognitive impairment and required limited to extensive assistance with care needs. The resident exhibited combativeness with care, resistance to care, delusions, hallucinations and agitation.</p> <p>Review of the comprehensive care plan for Resident #9 revealed the facility implemented an intervention to leave the resident alone when agitated. Documentation was not located to address interventions for the resident's behaviors of delusions, hallucinations and resistance to care.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident with diagnoses of Dementia with Behaviors, Impulse Control Disorder, Anxiety and Hypertension. The facility completed a Quarterly MDS assessment on 05/05/13 which revealed the resident was</p>	F 279		



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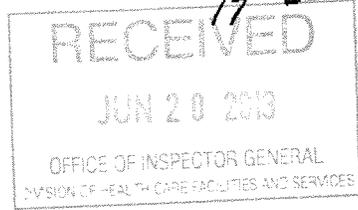
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F 279	<p>Continued From page 14</p> <p>cognitively intact and required extensive to limited assistance with care needs.</p> <p>Review of the care plan for Resident #10 revealed the resident exhibited restlessness, noncompliance with care and poor impulse control. The resident was redirected as needed. Evidence of interventions to address the resident's behaviors was not located.</p> <p>Interview with the Program Director, on 05/23/13 at 10:05 AM, revealed Resident #9's care plan should address each behavior with interventions for staff to follow.</p> <p>Review of the clinical record for Resident #19 revealed the resident was admitted by the facility with diagnoses of Bilateral Contractures, Dysphagia, Advanced Dementia, Anxiety and Depression. The facility completed a Quarterly MDS assessment on the resident on 04/09/13 which revealed the resident had a severe cognitive impairment. The resident required total assistance with all care needs. The resident received antianxiety and antidepressant medications.</p> <p>Review of the comprehensive care plan for Resident #19 revealed a care plan to implement interventions to monitor the resident for side effects and adverse drug reactions secondary to the use of antianxiety and antidepressant medications was not located. In addition, the resident's care plan to address the refusal to take medications was not located.</p> <p>Interview with the MDS Coordinator, on 05/23/13 at 10:15 AM, revealed</p>	F 279		
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F 279	Continued From page 15 care plans were developed after a comprehensive assessment was completed quarterly and when there were changes in the resident's care. The MDS Coordinator revealed the interdisciplinary team should have developed interventions to address behaviors and the use of psychotropic drugs.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>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.</i>	
F 282 SS=D	Interview with the Director of Nursing, on 05/23/13 at 2:00 PM, revealed her expectation was that all resident needs were addressed on the care plan to ensure residents received the appropriate care. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to follow the comprehensive plan of care for two (2) of the twenty-three (23) sampled and four (4) unsampled residents (Resident #9 and 16) for assistance during meal service. The findings include: Review of the facility's policy regarding Care Plans, dated 01/07/12, revealed the plan of care would be developed on the patient's individual	F 282	F 282 SS=D 483.20(k) (3) (ii) Services By Qualified Persons/Per Care Plan: I. How the corrective action will be accomplished for the resident affected: Resident #9 careplans was reviewed by the DNS and Program Director for the Unit and updated 6/11/13 to reflect location of staff during meals, as well as queing and reminder to resident, also educated is being conducted with staff on update and schedule to be completed by 7/5/13. Resident #16 was discharged on 5/30/13 to home with home health care. II. How corrective action will be accomplished for those residents having potential to be affected: The Unit Managers and Director of Nursing are reviewing all current residents for level of assistance required with meals and validating care plans specific for meal supervision and assistance needed. III. What measures will be out in place/systemic changes made to ensure correction: The dining procedure has changed to one seating experience with two	July 6, 2013 July 6, 2013 July 6, 2013

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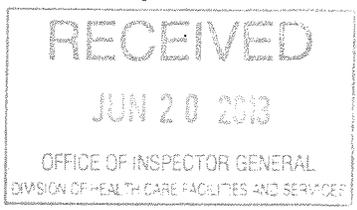
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F 282	<p>Continued From page 16</p> <p>needs as identified by assessments. Provided or arranged services in accordance with the residents written care plan meet professional standards of quality and are performed by qualified persons.</p> <p>Review of Resident #16's clinical record revealed the facility admitted the resident on 09/08/11 with diagnoses of Dementia, Difficulty Swallowing, and a Stroke. The facility utilized the Minimum Data Set (MDS), Dated 08/16/12, to assess the resident and identified the resident required a one person physical assist with eating, and had one sided upper extremity impairment. The Registered Dietician completed the Medical Nutrition Therapy Review, on 04/29/13, which revealed the resident was totally dependent with dining skills. The Medical Nutrition Therapy Review, dated 05/17/13, did not assess the resident's dining skills and the MDS signed 05/18/13 had the resident listed requiring set up help only for dining. Review of the resident's comprehensive plan of care revealed the resident should have assistance as needed during the dining service and should attend the Dependant Dining session.</p> <p>Observation of the evening meal service in the main dining room, on 05/21/13 at 5:10 PM, revealed Resident #16 was served his/her meal and two (2) cups were placed just out of the resident's reach. In addition, while attempting to feed his/her self Resident #16 continually dropped spoonfuls of the meal onto their shirt leaving the resident covered in food. After thirty (30) minutes of no assistance and surveyor intervention, CNA #7 sat with the resident, moved the cups within the residents reach and offered</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>process at all meals to ensure resident care plans is followed and any assistance being needed is immediately provided effective 5/24/13.</p> <p>All staff is being educated by the Director of Nursing on the new dining procedure and schedule to be completed by 7/5/2013.</p> <p>Dining Room Monitors and Program Director to perform weekly meal audits to ensure assistive devices are provided and level of assistance provided to residents is consistent with the residents' plan of care. Any concerns will be immediately corrected.</p> <p>IV. How the facility plans to monitor its performance to make sure the solutions are sustained: Dining Committee will meet monthly and minutes from dining committee meeting and results of the weekly meal audits will be reviewed through Performance Improvement Committee monthly for the next 6 months or until sustained compliance is achieved.</p>	July 6, 2013
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F 282	<p>Continued From page 17</p> <p>cueing and assistance to the resident.</p> <p>Interview with CNA #7, on 05/23/13 at 3:05 PM, revealed the resident did not like being helped, but stated the resident had worsened and needed more guidance therefore, someone should have gone over to assist the resident. The CNA revealed the cups were placed too far away and the resident was not able to reach them.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/23/13 at 4:00 PM, revealed she was the Unit Manager for the Twin Spires Crossing Unit. The LPN revealed Resident #16 required supervision and back up assistance. The LPN stated Resident #16 should have been placed where he/she could have been easily assisted.</p> <p>Observation of Resident #9 on 05/21/13 at 4:45 PM and on 05/22/13 at 12:20 PM and 4:55 PM revealed the resident in the dining room feeding self meals without staff sitting next to the resident</p>	F 282		
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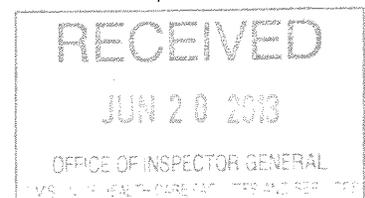
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F 282	<p>Continued From page 18</p> <p>during the meals. Staff members were in and out of the room as they went to the hallway to obtain tray for residents from the tray cart parked there.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident with diagnoses of Dementia, Seizures, Bipolar Disorder and Paranoid Schizophrenia. The facility completed a significant change MDS assessment for the resident on 04/18/13 which revealed the resident had a severe cognitive impairment, mood and behavior issues, and recent weight loss.</p> <p>Review of the comprehensive care plan for Resident #9 revealed the resident had a significant weight loss over a six (6) month time frame. Interventions were implemented for the resident to eat in an upright position, chew slowly and chew each bite thoroughly, observe for coughing or choking and to have a staff member sit with the resident at all meals and supervise the resident directly.</p> <p>Interview with Certified Nurse Aide #3 on 05/23/13 at 10:25 AM revealed staff did not sit with Resident #9 during meals. She stated staff would hear the resident coughing or choking and assist the resident. She stated she was not aware the staff were to sit with the resident and provide direct supervision. She agreed that staff were in and out of the room especially if a resident needed assistance to toilet during the time the meal was in progress.</p> <p>Interview with the Program Manager on 05/23/13 at 10:45 AM revealed the staff did not sit with Resident #9 during meals as the room was small</p>	F 282			

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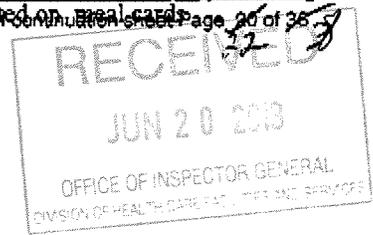
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F 282	Continued From page 19 enough to supervise the resident directly. She stated the resident had past issues with coughing during the meal. She stated the care plan was intended to assist the resident if choking were observed.	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 369 SS=D	Interview with the Director of Nursing on 05/23/13 at 2:00 PM revealed she expected resident care plans to be followed by staff to ensure the resident received the appropriate care. 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide special eating equipment for one (1) of twenty-three (23) sampled residents and four (4) unsampled residents. The facility staff failed to provide Resident #18 with a weighted cup with a lid for all liquids consumed during meals. The findings include: Review of the facility's policy titled Dining Skills Level (Revised 08/31/12), revealed a licensed nurse or another appropriate designee was assigned to monitor the restorative and assistive dining rooms for accuracy of the diet served, that appropriate assistive devices were in place, and that residents received verbal cues and/or	F 369	F 369 SS=D 483.35 (g) Assistive Devices-Eating Equipment/Utensils: I.How the correction action will be accomplished for those affected: Resident #18 was rescreened by Occupational Therapy on 5/24/13 and continues to require use of the specialized cup. The resident is receiving a separate specialized cup with each type of liquid offered with every meal. Additional specialized cups will be provided if more than two types of fluids for each. II.How corrective action will be accomplished for those residents having potential to be affected: Director of Nursing reviewed all physician orders for adaptive equipment and referred all residents with orders for adaptive equipment to therapy for screens to ensure all items were appropriate. The Nutrition Services Manager validated all tray cards reflect any adaptive equipment ordered for all current residents. III.What measures will be put in place/systemic changes made to ensure correction: Dining Room Monitors and Program Director were educated on monitoring the provision of assistive devices	July 6,2013 July 6,2013 July 6,2013



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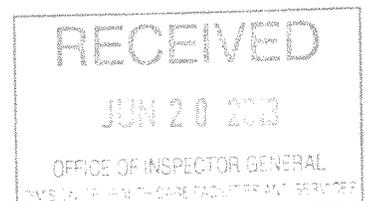
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F 369	<p>Continued From page 20 physical assistance with feeding as needed.</p> <p>Review Resident #18's clinical record revealed the facility admitted the resident on 09/28/04 with diagnoses of Alcohol-Induced Dementia, Bi-Polar Disorder, Schizoaffective Disorder, Hyperlipidemia; Unspecified Vitamin Deficiency, Hepatomegaly, and Cardiac Arrhythmias. Review of the Speech Therapy Department's evaluation of Resident #18 on 01/30/12 and again on 04/09/12 revealed the following recommendations were made: one to one (1:1) supervision during meals; and thin liquids in a cup with a lid related to multiple choking episodes that resulted from Resident #18's tendency to consume food and liquids too rapidly. Physician orders revealed the following diet/dining interventions on 09/04/12: a mechanical soft diet with regular liquids; a weighted cup with a lid; to be fed 1:1 by a care giver, and his/her food was to be offered in small bites. These interventions were listed within the nutrition component of Resident #18's comprehensive care plan and on the care card used by the Certified Nursing Assistants (CNAs) assigned to Resident #18.</p> <p>Observation, on 05/23/13 at 11:50 AM, revealed Resident #18 was seated in the dining room with a meal tray in front of him/her. One (1) weighted cup with a lid and a handle contained coffee, but the resident's milk was contained in two (2) clear plastic cups which did not have lids. The facility's Staffing Coordinator was seated next to Resident #18, and assisting him/her with the meal. During the meal, Resident #18 picked up one of the cups of milk, took a drink, and then managed to put it</p>	F 369	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>by the Registered Dietician by 7/5/13. Dining Room Monitors and Program Director to perform weekly meal observation audits to ensure assistive devices are provided and being used. Unit Managers and Program Director will use tool named "nutrition services evaluation: tray accuracy—(Form 05508-01) to perform audits. All findings during audit will be immediately corrected with education provided to responsible department. The audit will be ongoing weekly for three months. All dietary staff have been educated by the Registered Dietician on providing adaptive equipment as ordered by physicians and noted on tray cards. All nursing staff education is schedule to be completed by 7/1/13 on following tray cards for adaptive equipment with all meals. The education is being provided by Staff Development Coordinator.</p> <p>IV. How the facility plans to monitor its performance to make sure the solutions are sustained: Findings from the weekly meal observation audits will be reported to Director of Nursing and Nutritional Service Manager. This will be completed on a weekly basis. The findings of the audit will be tracked and trended through Performance</p>	July 6, 2013
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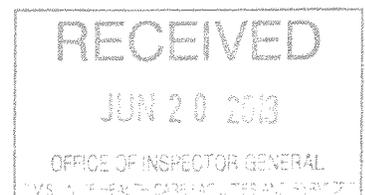
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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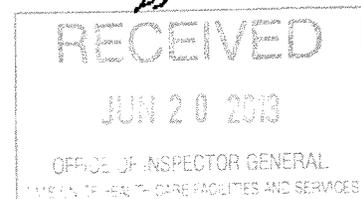
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F 369	<p>Continued From page 21 down without spilling the milk, but his/her hand shook continuously during the process.</p> <p>Interview, on 05/23/13 at 2:25 PM, with Dietary Aid #1 revealed she always set up Resident #18's tray with one (1) weighted cup with a lid because no one had requested more than one, and she always provided two (2) cartons of milk as that was printed on the tray ticket. Staff in the dining room was responsible for opening the cartons and pouring the liquids into cups for the residents.</p> <p>Interview, on 05/23/13 at 2:45 PM, with the Dietary Manager revealed the facility had several weighted cups with lids in two sizes and they were available for Resident #18's use upon request.</p> <p>Interview, on 05/23/13 at 1:40 PM, with the Staffing Coordinator revealed she was assigned to assist residents in the dining room with meals, and she had assisted Resident #18 in the past and on 05/23/13 during the noon meal. Her responsibility was to see that Resident #18 took smaller bites and drink his/her liquids more slowly to prevent a choking episode. The Staffing Coordinator stated Resident #18's hands did shake, but she had not seen him/her spill milk while drinking it from the regular cups. She thought the cup with a lid was used for hot liquids to prevent spillage that might cause a burn. The Staffing Coordinator stated a staff member was always assigned to monitor/assist/feed Resident #18.</p>	F 369	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>months. The Performance Improvement Committee will address any repeated concerns for further actions to prevent the deficient practice from reoccurring.</p>	



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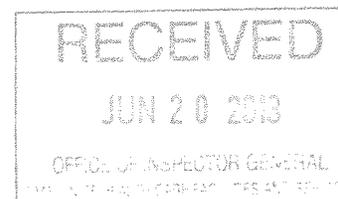
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218	
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F 369	Continued From page 22 Interview, on 05/23/13 at 3:00 PM, with the Interim Director of Physical, Occupational, and Speech Therapy revealed Resident #18 had the order for the weighted cup to assist the resident with drinking more slowly as he/she had a tendency to consume foods/liquids too rapidly and this increased the risk for choking. She stated she interpreted the current order to mean all liquids served to Resident #18 should be served in cups with lids. She was not sure who was responsible for educating staff members on the use of the adaptive equipment ordered for Resident #18's use during meals. Interview, on 05/23/13 at 2:00 PM, with Licensed Practical Nurse (LPN) #2, Unit Manager, revealed all staff assigned to Resident #18's care should know the purpose of the weighted cups, and exactly how all liquids should be served to the resident. LPN #2 stated she would be responsible for ensuring that staff understood how to set up the resident's meal tray, and assist the resident during meals. Interview, on 05/23/13 at 3:20 PM, with the Director of Nursing Services (DNS) revealed Resident #18 needed 1:1 supervision when he/she ate, and a weighted cup was in place because of his/her tendency to drink too rapidly. She stated she knew it had been necessary for staff to sometimes physically put the cup to the resident's mouth to help him/her take smaller sips when observed taking in too much fluid at one time. The DNS stated she would interpret the current physician's order for adaptive equipment to mean a lidded cup was to be provided for all	F 369		



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F 369	Continued From page 23 liquids served to Resident #18. The DNS stated staff members received orientation on how to feed residents upon hire and on an as needed basis, but it was ultimately her responsibility, as Director of Nursing Services, to ensure the residents' care needs were met at all times. Observation of the evening meal service during the dependant dining session in the dining room, on 05/21/13 at 4:52 PM, revealed Resident #18 had a mug with a lid sitting on the table. The resident was noted to have tremors to their upper extremities. Certified Nursing Assistant (CNA) #8 was observed opening 2 cartons of milk and pouring them into two (2) clear plastic cups without a lid or handle. The resident was observed reaching for the milk and holding it in their tremulous hands. The CNA then took the cup out of the resident's hand and said to the resident remember you spill it all over yourself, let me help you. The resident then reached for the handled mug with a lid and successfully drank from the cup independently without assistance. Observation of the afternoon meal during the dependant dining session in the dining room, on 05/22/13 at 11:45 AM, revealed the Staffing Coordinator gave the resident coffee in a handled mug with a lid, but while setting up Resident #18's meal tray the Staffing Coordinator poured the 2 cartons of milk into clear plastic cups with no handle or lid. CNA #6 was then observed	F 369			



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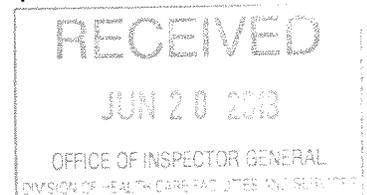
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F 369	<p>Continued From page 24</p> <p>assisting the resident with the meal and holding the cup for the resident.</p> <p>Interview with CNA #6, on 05/23/13 at 2:12 PM, revealed the resident should use the blue cup with the lid. The CNA revealed the lid slows the flow of the liquid because the resident tends to eat and drink to fast. The CNA revealed hot liquids were usually placed in the lidded cup due to the residents tremors to prevent spillage. The CNA revealed the cup was used for both reasons, prevent spillage and to slow the flow; however, the CNA revealed she did not know why more lidded mugs were not provided for the resident when other residents received enough cups for each liquid. The CNA revealed staff used the tray card to determine assistive devices and was aware Resident #18's tray card called for lidded mugs. The CNA revealed she did not ask for more lidded mugs.</p> <p>Interview with CNA #8, on 05/23/13 at 2:35 PM, revealed he was aware the resident was to have lidded mugs due to the resident's tremors. The CNA revealed the coffee was normally placed in the mug and the milk was put in a regular cup because if something was going to spill they would rather the resident not get burned. The CNA revealed he did not know why more lidded mugs were not provided, but had never asked because he was told that was what staff were to do.</p>	F 369	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F371 SS=F 483.359(i) Food Procure, Store/Prepare/Serve-Sanitary:</p> <p>1. How corrective action will be accomplished for those affected: The Nutrition Services Manager and Registered Dietitian in-serviced all dietary staff 6/10/2013 on hand-washing and measuring food temperatures using procedure #68009 "Hand Hygiene/Hand-washing" and #68028 "Measuring Food Temperatures". Additionally Dietary Cook #1 was counsel by the Dietary Manager for failing to follow hand washing and correct use of thermometer on 5/31/13.</p> <p>2. How corrective action will be accomplished for those residents having the potential to be effected: All residents have the potential to be effected. The Nutrition Services Manager and Registered Dietitian in-serviced all dietary staff 6/10/2013 on hand-washing and measuring food temperatures using procedure #68009 "Hand Hygiene/Hand-washing" and #68028 "Measuring Food Temperatures".</p>	July 6,2013
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local</p>	F 371	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY:</p> <p>1. How corrective action will be accomplished for those affected: The Nutrition Services Manager and Registered Dietitian in-serviced all dietary staff 6/10/2013 on hand-washing and measuring food temperatures using procedure #68009 "Hand Hygiene/Hand-washing" and #68028 "Measuring Food Temperatures".</p>	July 6,2013



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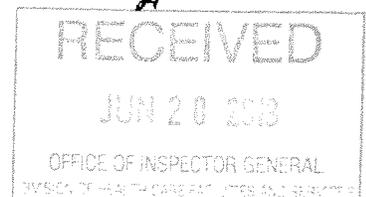
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F 371	<p>Continued From page 26</p> <p>11:50 AM, revealed a piece of corn fell on Dietary Cook #1's gloved hand while making a resident's plate. Dietary Cook #1 then placed the corn on her gloved hand back onto the resident's plate.</p> <p>Observation of the Tray Line, on 05/22/13 at 11:55 AM, revealed Dietary Cook #1 was observed to have dropped the lid of a glass of milk into the taco casserole and placed the lid back onto the glass of milk.</p> <p>Observation of the Tray Line, on 05/22/13 at 12:00 PM and 12:10 PM, revealed Dietary Cook #1 was making a resident's plate and found ice to be in the salad. Dietary Cook #1 then, with gloved hands, removed the ice from the resident's salad and placed it onto the steam table.</p> <p>Interview with the Dietary Cook #1, on 05/23/13 at 2:28 PM, revealed she was taught to not touch food because it may cause infections. Dietary Cook #1 stated she must have been nervous because she was not aware she placed the corn back onto a residents plate.</p> <p>Interview with Dietary Cook #2, on 05/23/13 at 2:23 PM, revealed staff were not to touch food with their hands. Dietary Cook #2 stated she was educated to use tongs. She stated placing corn back onto a plate of food was not appropriate.</p> <p>Interview with the Dietary Manager (who has been Manager for six (6) weeks), on 05/23/13 at 2:28 PM, revealed the staff should not have touched the food because of cross contamination.</p> <p>2. Record review of the Hand</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p>	
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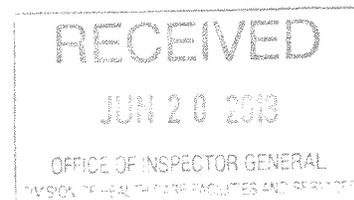
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F 371	<p>Continued From page 27</p> <p>Hygiene/Handwashing policy, revised 08/31/11, revealed handwashing was the single most important procedure for preventing the spread of infection. Hand hygiene should be performed before donning gloves to work with food.</p> <p>Observation of the Tray Line, on 05/22/13 at 12:10 PM, revealed Dietary Cook #1 removed her gloves as she went into the fridge to retrieve a fruit salad. Dietary Cook #1 then put on gloves without washing her hands and continued to make plates for the residents.</p> <p>Observation of the Tray Line, on 05/22/13 at 12:15 PM, revealed Dietary Cook #1 removed her gloves again to retrieve a fruit salad out of the refrigerator. Dietary Cook #1 then put on new gloves without washing her hands to continue the tray line service.</p> <p>Interview with Dietary Cook #1, on 05/23/13 at 2:10 PM, revealed she was aware she should change her gloves, but was not aware she needed to wash her hands between glove removal. Dietary Cook #1 was aware that washing her hands was for cleanliness and to prevent the spread of infections.</p> <p>Interview with Dietary Cook #2, on 05/23/13 at 2:23 PM, revealed she was educated about how to take your gloves off, to remove the gloves inside out and wash hands while singing the birthday song to prevent the spread of germs. Dietary Cook #2 stated this procedure should be completed before putting on new gloves.</p> <p>Interview with the Dietary Manager, on 05/23/13 at 2:28 PM, revealed he was familiar with staff</p>	F 371		
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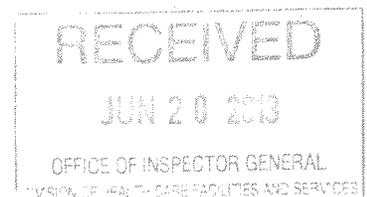
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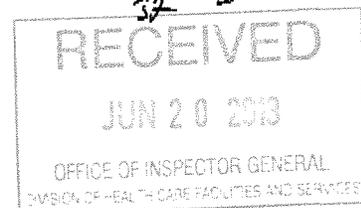
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F 371	<p>Continued From page 28</p> <p>needing to wash their hands after glove removal. He stated they wash their hands to prevent the spread of bacteria and germs.</p> <p>3. Observation of the Tray Line, on 05/22/13 at 11:30 AM, revealed while Dietary Cook #1 was obtaining temperatures (without gloves on) of the taco casserole, pureed rice and taco meat sauce, the base of the thermometer (contaminated by the cook's bare hands) was observed to touch these food items. Dietary Cook #1 was observed to clean the thermometer with alcohol, but did not clean the base with the alcohol swab, thus contaminating the next food item that was to be temped.</p> <p>Interview with Dietary Cook #1, on 05/23/13 at 2:10 PM, revealed she was not aware she was allowing the base of the thermometer to touch the food. Dietary Cook #1 stated she was taught to not allow the base to touch the food because of cross contamination.</p> <p>Interview with the Dietary Cook #2, on 05/23/13 at 2:23 PM, revealed staff should not place the base of the thermometer into the food because their hands hold on to the thermometer and can contaminate the food.</p> <p>Interview with the Dietary Manager, on 05/23/13 at 2:28 PM, revealed the base of the thermometer should not go into the food. When food was not cleaned off the thermometer as it should, the food residue can cause cross contamination.</p> <p>Interview with the Registered Dietician (RD), on 05/23/13 at 2:40 PM, revealed she helped in the</p>	F 371		



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F 371	Continued From page 29 training of the Dietary Manager. The RD stated since the new Dietary Manager had been there, there has not been any in-services completed. The RD stated usually they have in-services every month, but the last formal training was on sanitation, washing of hands, cleaning schedules, and temperatures of food, etc. The RD stated she did not witness the base of the thermometer going into food and the base of the thermometer should never go into the food because you can contaminate the food. The RD stated she had educated the staff to wash their hands when they removed their gloves.	F 371	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>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.</i>	
F 441 SS=E	Record review revealed the last official training occurred on 01/10/13 in regards to hand washing and general sanitation. 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 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	F 441	F441 SS=E 483.65 Infection Control, Prevent Spread, Linens: I. How the corrective action will be accomplished for affected Resident: Certified Nurse Aides #4, #3, #10, and Program Director of the locked unit are schedule to be completed education by Staff Development Coordinator by 7/1/13 on the policy and procedure for proper handwashing. Aide #5 and all aides are schedule to be educated by 7/1/13 to not sit on the floor. II. How corrective action will be accomplished for those residents having potential to be affected: All residents have the potential to be affected. III. What measures will be put in place/systemic changes made to ensure correction: SDC/infection control nurse will perform observation audits to ensure guidelines for infection control are being met. These audits to be twice a week on all units. The audit will include observing handwashing of at least 3 staff members. Any deficient practice to be corrected immediately and education to occur. The other audit will be	July 6, 2013 July 6, 2013 July 6, 2013



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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218		
(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 441	<p>Continued From page 30</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure infection control practices were followed when four (4) of four (4) employees providing direct resident care on the locked unit failed to wash their hands per the facility policy, two (2) of twenty-three (23) sampled residents (Residents #3 and #6) and four (4) unsampled residents had indwelling catheter bags in direct contact with the floor and staff were noted to sit on the floor in the physical therapy room.</p> <p>The findings include: Review of the facility's policy regarding Resident Health Program, dated 09/22/09, revealed the program was to establish, obtain, and maintain an</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>monitoring. All findings will be reported to Director of Nursing. Director of Nursing will report findings to Performance Improvement Committee and will be tracked and trended for the next six months.</p> <p>IV. How the facility plans to monitor its performance to make sure the solutions are sustained: : All audit results will be reported monthly by the DNS and tracked and trended through the Performance Improvement Committee monthly for the next 6 months and the frequency of the audits may be increased or decreased based on the findings. The Performance Improvement Committee will continue to monitor findings from the audits until compliance is sustained.</p>	July 6, 2013	

JUN 20 2013

DIRECTOR GENERAL

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

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 3635 BARDSTOWN ROAD LOUISVILLE, KY 40218
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F 441	<p>Continued From page 31</p> <p>optimum level of wellness in the facility. The policy contained no information regarding the protection of residents from staff or facility practices that placed residents at risk for infection.</p> <p>Review of the facility's policy regarding Hand Hygiene/Handwashing, dated 08/31/11, revealed handwashing was the single most important procedure for preventing the spread of infection. Hand hygiene was to be performed before donning gloves to work with food. When using soap and water, the staff was to rub hands vigorously for twenty (20) seconds.</p> <p>Observation of the meal service on the locked unit, on 05/22/13 at 12:05 PM, revealed staff assisting residents into the dining room. The tray cart arrived on the unit at 12:15 PM. Certified Nurse Aide (CNA) #4 was observed to wash his hands at the sink for four (4) seconds. CNA #3 was observed to wash her hands for ten (10) seconds. The Program Manager was observed to wash her hands for eight (8) seconds and CNA #10 was observed to wash her hands for nine (9) seconds. All four (4) were then observed to assist residents with their meal trays.</p> <p>Observation of the Physical Therapy room, on 05/23/13 at 9:50 AM, revealed CNA #5 sitting on the floor, in her uniform, in the therapy room.</p> <p>Interview with CNA #5, on 5/22/13 at 12:50 PM, revealed she liked to sit on the floor and talk to the residents. She stated she had never thought that the practice contaminated her uniform; however, she saw that it was not a good practice since the bacteria on the floor was now on her</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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F 441	<p>Continued From page 32</p> <p>uniform and could be spread to residents when she delivered care. She stated no one had ever told her not to sit on the floor.</p> <p>Interview with CNA #4, on 05/22/13 at 12:20 PM, revealed when hands were washed with soap and water they should be rubbed together for two (2) minutes. He stated this was facility policy. He stated he did not realize he washed his hands for four (4) seconds. He stated he had received training from the facility and not washing hands for long enough would not remove bacteria and could make residents sick.</p> <p>Interview with CNA #3, on 05/22/13 at 12:25 PM, revealed when washing hands using soap and water, hands should be washed for thirty (30) seconds. She stated she did not realize she completed the task in ten (10) seconds. She stated she had received training for handwashing and the procedure helped prevent the spread of infection to residents.</p> <p>Interview with the Program Manager, on 05/22/13 at 12:30 PM, revealed the facility policy for handwashing with soap and water stated hands were rubbed together for fifteen (15) to twenty (20) seconds. She stated she was not aware that she washed her hands for eight (8) seconds. She stated this was not long enough to remove bacteria from her hands. She stated bacteria could make residents sick.</p> <p>Interview with CNA #10, on 05/22/13 at 12:35 PM, revealed she was trained on proper handwashing. She stated the facility policy when using soap and water was to rub hands together for three (3) minutes. She did not realize she had rubbed her</p>	F 441		
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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F 441	<p>Continued From page 33</p> <p>hands together for nine (9) seconds. She stated bacteria could spread to residents when hands were washed incorrectly.</p> <p>Interview with the Director of Nursing, on 05/23/13 at 1:00 PM, revealed her expectation was that staff would follow the facility policy regarding hand washing to prevent the spread of infection to residents. In addition she stated nursing staff were not to sit on the floors as the practice contaminated their uniforms.</p> <p>Review of the facility's policy and procedure on Indwelling Urinary Catheter Care, revised date 08/31/12, revealed care of a catheter was to prevent infection. The procedure was to position the collecting bag below the level of the bladder at all times and not to rest the bag on the floor.</p> <p>Observation of Resident #6, on 05/22/13 at 8:10 AM and at 11:10 AM, revealed the urine collection bag in a dignity bag was placed on the right side of the bed and laid on the floor.</p> <p>Observation of Resident #3, on 05/22/13 at 11:05 AM and on 05/23/13 at 2:20 PM, revealed the urine collection bag was attached to the side of the bed. The bed was in a low position with the urine collection bag on the floor.</p> <p>Clinical record review revealed Resident #3 was admitted on 07/27/12 with diagnoses of Adult Failure to Thrive, Anemia, Pressure, Paralysis Agitans, Anorexia, Parkinson's Disease, Progressive Dementia and Anxiety. The facility completed a Quarterly Minimum Data Set (MDS), dated 04/27/13, that determined the resident's</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218	
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F 441	Continued From page 34 cognitive skills for daily decision making was severely impaired. Clinical record review revealed Resident #6 was readmitted on 01/24/13, with diagnoses of Vitamin Deficiency, Hypertension, Pressure Ulcer, Leg Varicosity with an Ulcer, Dementia, Depressive Psychosis, Diabetes Mellitus, Anemia and Cerebrovascular Accident (CVA). The facility completed a Quarterly Minimum Data Set (MDS), dated 04/04/13, that indicated the resident's cognitive skills for daily decision making was severely impaired. Interview with Registered Nurse #2, on 5/23/13 at 2:45 PM, stated the urine collection bags were to kept in a dignity bag and hung on the bedside. The urine collection bag should not touch the floor or the fall mats. The bag should be kept off the floor because infections were the concern from them being in the floor, and the fall mats were considered to be a dirty area as they lay on the floor. The bedside collection bags are to be below the level of the bladder and not on the floor or fall mats. Interview with the Nurse Consultant, on 5/23/13 at 3:00 PM, reported the urine collection bags should be kept off of the floor. Facility practice was to hang them in a manner for the urine collection bag to not touch the floor. The potential for infection was a concern when the urine collection bag was in contact with the floor or on the fall mats. Interview with the Director of Nursing, on 5/23/13 at 3:30 PM, revealed as long as the urine collection bag was in the dignity bag there was	F 441		

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F 441	Continued From page 35 not a concern of infection when the urine collection bag was on the fall mats.	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-BASHFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1960, 1962, 1988

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story with a partial basement; Construction Type III, Unprotected.

SMOKE COMPARTMENTS: Ten (10) smoke compartments.

FIRE ALARM: Complete fire alarm system with heat and smoke detectors.

SPRINKLER SYSTEM: Complete automatic, dry sprinkler system.

GENERATOR: Type II, 350 KW generator. Fuel source is diesel.

A standard Life Safety Code survey was conducted on 05/22/13. Kindred Nursing and Rehabilitation - Bashford was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance 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 <i>[Signature]</i>	TITLE Administrator	(X8) DATE 6/20/13
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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.

JUN 20 2013
If continuation sheet Page 1 of 1
OFFICE OF INSPECTION AND COMPLIANCE
DIVISION OF HEALTH CARE REGULATION