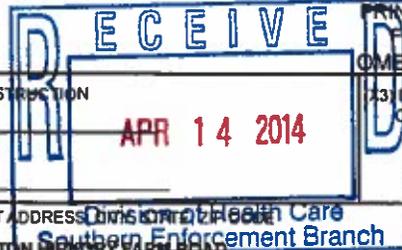


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER	STREET ADDRESS 65 MINTON BIRKBEY FARM ROAD BARBOURVILLE, KY 40906
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	See a Hatched	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Janna Partin</i>	TITLE Administrator	(X8) DATE 4/14/14
--	------------------------	----------------------

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.

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the physician was notified when there was a change in a resident's physical condition for (1) of twenty-four (24) sampled residents (Resident #8).</p> <p>The findings include:</p> <p>A review of the facility's policy entitled, "Notification of Change in Resident's Status," undated, revealed the attending physician or their alternate was to be notified of any change in a resident's condition. The policy stated the changes included, but were not limited to, a significant change in the resident's physical, mental, or psychosocial status, in either a life threatening or clinical condition or a need to alter treatment.</p> <p>Review of Resident #8's medical record revealed the facility admitted the resident on 09/23/13 with diagnoses including Leukocytosis, Stroke, Dementia, Right Hemiparesis, Anorexia, Anemia, and Lymphoma. Further review of the clinical record revealed on 03/12/14, the facility assessed Resident #8 to have a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.</p> <p>Observation and interview with Resident #8 on 03/18/14 at 11:03 AM revealed State Registered Nurse Aide (SRNA) #10 was providing a bed bath for the resident. The resident's eyes were red and draining. The resident's right eye was observed to be matted shut. SRNA #10 stated</p>	F 157			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906
--	--

(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 157	<p>Continued From page 2</p> <p>she let the resident wash his/her eyes because the resident's eyes were painful. She said the resident's eyes drained all the time and that normally by the time the resident's bath was complete, the resident's eye would be crusted again. SRNA #10 stated she assumed facility nurses were aware the resident's eyes were draining and matted because they were in that condition when the SRNA began working at the beginning of March 2014. Resident #8 stated that his/her eyes burn and hurt and staff had put drops in his/her eyes one time.</p> <p>Further observation and interview with Resident #8 on 03/18/14 at 5:35 PM revealed the resident was eating the evening meal and the resident's right eye was matted shut. The resident stated his/her eyes were painful and had been painful for a few months.</p> <p>Interview with SRNA #5 on 03/18/14 at 2:55 PM, revealed that Resident #8's eyes had been draining and matted for about one month.</p> <p>Interview with SRNA #11 on 03/18/14 at 5:40 PM revealed Resident #8's eyes had been red for a "few days."</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 03/18/14 at 2:53 PM, revealed Resident #8's eye infection "comes and goes"; the resident had received eye ointment for seven days in the past and the resident's eyes got better and then got worse. LPN #4 stated that she had not observed Resident #8's eyes draining, but they did get red and the redness went away. LPN #4 further stated that no one had reported that the resident's eyes were matted.</p>	F 157		
-------	--	-------	--	--

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 157	Continued From page 3 Interview with LPN #2 on 03/19/14 at 2:23 PM and LPN #3 on 03/19/14 at 2:43 PM revealed they were aware the resident's eyes were red, but had not seen any drainage. The LPNs stated they would notify the resident's physician if drainage was present. Interview with LPN #1, who was also the Clinical Coordinator, on 03/19/14 at 2:04 PM, revealed she considered eyes that were red and draining to be a change in condition which would require notifying the resident's physician. Interview with the Director of Nursing (DON) on 03/20/14 at 5:07 PM, revealed that she had done eight o'clock rounds the day before and had not identified any problems with Resident #8's eyes.	F 157			
F 282 SS=E	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 review of the facility policy, it was determined the facility failed to provide services in accordance with the plan of care for four (4) of twenty-four (24) sampled residents (Residents #2, #4, #17, and #20). According to the care plans for Residents #2, #4, #17, and #20, the residents' fingernails/toenails were to be kept clean and groomed; however, observations on 03/18/14, 03/19/14, and 03/20/14 revealed staff	F 282	See attached		

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	<p>Continued From page 4</p> <p>failed to provide nail care and the residents' fingernails/toenails were long and unkempt.</p> <p>The findings include:</p> <p>Review of the Care Plan Policy and Protocol (revised August 2012) revealed a Comprehensive Care Plan would be developed for each resident to meet that resident's medical, nursing, mental, and psychosocial needs. The policy further stated the Kardex would also be utilized as a guide for Nurse Aides in providing care on a daily basis.</p> <p>1. Review of Resident #2's medical record revealed diagnoses that included CVA with left-sided Hemiplegia (paralysis), Chronic Obstructive Pulmonary Disease, High Blood Pressure, and Chronic Pain Syndrome. A review of Resident #2's care plans revealed staff assessed the patient to have a self-care deficit and was dependent for Activities of Daily Living. Interventions identified to address the resident's self-care deficit included to keep the resident's nails clean and groomed. A handwritten note was observed on the Plan of Care that the resident refused AM care at times (shaving, baths, nail care, etc.). Further review of the medical record revealed a Treatment Record for Resident #2 dated March 2014 that indicated "Nurse Aide day nail care weekly on Sunday and as needed. If the resident is a diabetic, may do filing and shaping of nails only." The Treatment Record had been signed to indicate the resident's nails had been cut and cleaned; there was no documentation to indicate the resident had refused the services provided. The Resident Kardex also revealed Resident #2 required assistance of one staff person for personal hygiene.</p>	F 282			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	Continued From page 5 Observations of Resident #2 on 03/18/14 at 2:30 PM and 5:05 PM, and on 03/19/14 at 9:30 AM and 1:45 PM revealed the resident had long fingernails with a brown substance under the nails, and long toenails. During wound care observation, Licensed Practical Nurse (LPN) #3 was made aware of the resident's long fingernails and toenails. Interview with LPN #3 on 03/19/14 at 2:00 PM revealed the State Registered Nurse Aides (SRNAs) were to clean/cut nails if the resident did not have Diabetes or thick nails, every week and as needed, and the LPN stated the nurses were to monitor and check that nail care had been provided for the residents. LPN #3 acknowledged Resident #2 needed to have nail care provided and immediately cut the resident's nails and cleaned the brown substance from under the resident's fingernails. Interview with SRNA #1 on 03/19/14 at 2:10 PM revealed staff was to cut and clean fingernails and toenails weekly and as needed if the residents did not have Diabetes as a diagnosis. SRNA #1 stated she had not noticed that Resident #2's fingernails or toenails needed to be cut/cleaned, and said she had been concerned with shaving Resident #2 and had not seen the long/unkept nails. Interview with the Clinical Coordinator for the 200 Hall on 03/19/14 at 2:05 PM revealed SRNAs were to cut and clean nails every week and as needed for those residents without Diabetes or thick nails, and the nurses were to cut and clean residents with Diabetes. The Clinical Coordinator said staff was to assess residents for nail care	F 282			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	<p>Continued From page 6</p> <p>and stated she had not noticed Resident #2's nails being long and unkempt. The Clinical Coordinator said Resident #2 did not have a diagnosis of Diabetes and stated the SRNAs should have cut and cleaned Resident #2's nails.</p> <p>2. Review of the medical record revealed the facility admitted Resident #4 on 02/07/13 with diagnoses including Multiple Spinal Fractures, Hypertension, Arthritis, Extensive Peripheral Vascular Disease, and History of Right Femoropopliteal By-pass.</p> <p>Review of the quarterly MDS assessment dated 03/07/14, revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident's cognition was severely impaired. In addition, based on the assessment the resident required extensive assistance of one staff person for personal hygiene needs and the total assistance of two staff persons for bathing. Review of the comprehensive care plan for Resident #4 revealed the facility developed interventions that addressed the resident's self-care deficit that included bathing the resident, providing assistance with dressing, and keeping the resident's nails clean and groomed. According to the Resident Kardex (a guide used by the nursing assistants for providing resident care needs), the resident's personal hygiene needs would be provided by the nursing assistant.</p> <p>Resident #4 was observed on 03/18/14, at 11:30 AM to be lying in bed positioned on his/her back with bilateral fall mats on the floor. A skin assessment conducted with Licensed Practical Nurse (LPN) #7 and Registered Nurse (RN) #2 on 03/18/14, at 3:30 PM, revealed the resident</p>	F 282			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	<p>Continued From page 7</p> <p>had a scar on the right heel and a closed reddened area on the right outer ankle. Further observation revealed the resident's left great toenail was long and thick and the remaining toenails on both feet were long and in need of trimming/grooming.</p> <p>Interview with LPN #7 on 03/18/14, at 11:35 AM revealed the nurse aides were responsible to trim/groom the non-diabetic residents' fingernails and toenails each Sunday and as needed. The LPN stated she had not seen Resident #4's feet in "a while" but did not recall the toenails being "that" long.</p> <p>Interview conducted with State Registered Nurse Aide (SRNA) #6 on 03/20/14, at 2:30 PM revealed she was routinely assigned to Resident #4 each week. The SRNA stated the Nursing Kardex was used to provide guidance related to resident care needs. SRNA #6 also stated nail care was to be provided for non-diabetic residents on Sundays by the nursing assistants. SRNA #6 stated she could not recall when she had trimmed Resident #4's toenails, but stated she did not believe she had provided nail care since December 2013.</p> <p>Interview with SRNA #7 on 03/20/14, at 3:10 PM, also confirmed the Nursing Kardex was to be used to provide personal hygiene care and nail care was to be provided for non-diabetic residents on Sundays and as needed. SRNA #7 stated she had not provided nail care for Resident #4. The SRNA stated the resident's great toenail was too thick to cut and the resident's toenails had "been that way" since the resident was admitted to the facility.</p>	F 282			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	<p>Continued From page 8</p> <p>Interview with LPN #5 on 03/20/14, at 4:15 PM revealed she was the Clinical Coordinator for the 100 Hall and was responsible to ensure care plan interventions were provided by the nursing assistants. LPN #5 stated assigned rounds were conducted daily by the department managers to ensure care plan interventions were implemented. The LPN also confirmed the SRNAs were responsible to follow the Nursing Kardex to provide personal hygiene needs, including nail care for the residents. The LPN also stated the SRNAs were responsible to provide nail care for non-diabetic residents. LPN #5 stated no one had reported a problem with Resident #4's toenails to her and she was not aware the resident's toenails had not been trimmed.</p> <p>Interview with the Director of Nursing (DON) on 03/20/14, at 5:10 PM, revealed the nurses were responsible to monitor resident care needs to ensure care plan interventions were consistently implemented. The DON stated all supervisors were responsible to conduct resident rounds every two hours to ensure care needs including nail care were provided. The DON stated no problems with resident care needs being provided in accordance with the resident's care plan had been identified.</p> <p>3. A review of Resident #17's medical record revealed the resident had diagnoses that included Anemia, Diabetes, history of a stroke, and Dementia.</p> <p>A review of Resident #17's care plan revealed the facility identified that the resident had a self-care deficit and was dependent on staff for Activities of Daily Living (ADL). The facility developed an</p>	F 282			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	<p>Continued From page 9</p> <p>intervention to "keep nails clean and groomed." Further review of the medical record revealed a Treatment Record for Resident #17 for March 2014 with a treatment for "diabetic nail care weekly per nurse on skin assessment days and prn [as needed]."</p> <p>Observation and interview with Resident #17 on 03/19/14 at 3:25 PM with an SRNA revealed the resident's right great toenail was long, thick, and growing in toward the resident's second toe. The skin on the second toe of the right foot was observed to be red where the nail on the great toe rested on the second toe. The toenails of the second, third, and fifth toe of the right foot were thick and long. Further observation revealed the left great toenail was thick and long and the toenail was observed to be grown out and back over the base of the toenail. Observation revealed the second and third toenails of the left foot were also long. Further observation revealed the resident voiced pain during the observation of the feet when the SRNA touched the resident's toenails. Resident #17 stated his/her toes were painful and his/her toenails had not been trimmed since residing at the facility.</p> <p>Interview with LPN #2 on 03/20/14 at 3:19 PM revealed she conducted skin assessments, but Resident #17 frequently refused to let her look at his/her feet. LPN #2 stated she was not aware the resident's toenails "looked like that."</p> <p>Interview with SRNA #1 on 03/20/14 at 1:30 PM revealed Resident #17 threatened to kick the SRNA in the face when she attempted to touch his/her toenails. SRNA #1 stated the resident's nails had been that way ever since she had taken care of the resident. The SRNA further stated it</p>	F 282			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	<p>Continued From page 10</p> <p>had "been a while" since she had told a nurse about his/her nails.</p> <p>Interview with SRNA #4 on 03/20/14 at 1:26 PM revealed Resident #17's toenails had "been like that a while." SRNA #4 stated nursing assistants did not trim Resident #17's toenails because the resident was diabetic, but had reported to nursing staff that the resident's toenails needed attention.</p> <p>Interview with LPN #2 on 03/19/14 at 2:23 PM, with LPN #3 on 03/19/14 at 2:43 PM, and with LPN #4 on 03/19/14 at 2:58 PM revealed that nurses were required to provide nail care for diabetic residents. LPN #2 stated nail care was provided one day per week, mostly on Sundays, and was documented on the resident's treatment record. Further interview revealed a resident needed to see a podiatrist when nails were thick; toes were red, painful, inflamed; and/or ingrown.</p> <p>Interview with the Clinical Coordinator for the 200 Hall on 03/19/14 at 2:04 PM revealed nurses were required to trim and clean nails of residents with a diagnosis of Diabetes weekly and as needed, usually on Sundays or on days a skin assessment was required. The Clinical Coordinator stated she monitored residents by performing rounds a few times a day, in random rooms.</p> <p>Interview with the Director of Nursing (DON) on 03/20/14 at 5:07 PM revealed supervisors conducted rounds on every resident every two hours to monitor residents' care, including nail care. The DON stated she had not identified any problems with nail care. The DON further stated it was the nurses' responsibility for setting up arrangements for residents to see a podiatrist if</p>	F 282			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 66 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	<p>Continued From page 11</p> <p>needed. The DON stated she had not seen Resident #17's nails in a while. She stated Resident #17 had been to a podiatrist, but could not remember the date. The DON stated she believed the resident would not go back to the podiatrist.</p> <p>4. Review of Resident #20's medical record revealed the resident had diagnoses that included Muscle Weakness, Diabetic Neuropathy, Type 2 Diabetes Mellitus, Dementia, Chronic Obstructive Pulmonary Disease, Degenerative Disc Disease, and Arthritis.</p> <p>A review of Resident #20's care plan revealed the resident had a self-care deficit and was dependent upon staff for activities of daily living (ADL). The facility developed an intervention to "keep nails clean and groomed." Further review of the medical record revealed a Treatment Record for Resident #20 for March 2014 with a treatment for "Diabetic Nail Care Weekly per Nurse on Skin Assessment Days and PRN [as needed]." The Treatment Record had been signed on 03/05/14, 03/12/14, and 03/19/14 indicating the nails were trimmed and cleaned weekly. Review of the weekly skin assessments for Resident #20 dated 03/05/14, 03/12/14, 03/13/14, and 03/19/14 did not indicate that the resident had long toenails.</p> <p>Observation of Resident #20 on 03/20/14 at 1:54 PM revealed that the resident had long and thick toenails on all five toes on both the left foot and right foot.</p> <p>Interview with the Clinical Coordinator for the 200 Hall on 03/19/14 at 2:05 PM revealed the State Registered Nurse Aides (SRNAs) are required to</p>	F 282			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 282	Continued From page 12 cut and clean residents' nails every week and as needed for those residents without Diabetes or thick nails. The Clinical Coordinator stated nurses were required to trim and clean nails for residents that had a diagnosis of Diabetes. Interview with SRNA #9 on 03/20/14 at 1:54 PM revealed that nurses were required to do nail care on residents who had a diagnosis of Diabetes. SRNA #9 stated that she had reported to nurses that Resident #20 had long toenails; however, SRNA #9 stated that she could not remember which nurse she had told about the resident's toenails but stated that she had told "all" of the nurses. Interview with RN #3 on 03/20/14 at 3:13PM revealed that she was responsible for the nail care of residents that were diagnosed with Diabetes. RN #3 stated that she had conducted weekly skin assessments on Resident #20 but had not requested that the resident get an appointment to see a podiatrist in order to get his/her toenails cared for properly. RN #3 stated that she had filed the resident's toenails and stated that she did not know why she had not notified anyone concerning the resident's toenails. Interview with the DON on 03/20/14 at 5:17 PM revealed that she was not aware that Resident #20 had long toenails. She stated that the last time she looked at them they "were not bad." She also reported that nursing staff should have reported to her when they identified any resident concerns.	F 282			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312	See attached		

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 312	<p>Continued From page 13</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to ensure one (1) of twenty-four (24) sampled residents (Resident #2) received the necessary care and services to maintain good grooming and personal hygiene. Resident #2 was observed to have a dark brown substance underneath the resident's fingernails on two consecutive days of the survey, 03/18/14 and 03/19/14.</p> <p>The findings include:</p> <p>Review of the "Protocol for Nail Care" (not dated) revealed nail care for all residents that did not have a diagnosis of Diabetes would have nail care provided weekly per Nurse Aide as needed and the nail care would be documented on the Nurse Aide flow sheets.</p> <p>Review of Resident #2's medical record revealed Resident #2 was dependent upon staff for activities of daily living. Resident #2's medical diagnoses included Dysmotility, Cerebrovascular Accident (CVA) with left sided paralysis, and High Blood Pressure. Review of the Treatment Record revealed Nurse Aides provided nail care weekly on Sundays and as needed for Resident #2. There was no indication on the Treatment Record</p>	F 312			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 66 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 312	<p>Continued From page 14 of Resident #2 refusing nail care.</p> <p>Interview with Resident #2 on 03/18/14 at 3:40 PM revealed the resident wanted his/her fingernails and toenails cut/cleaned and was unable to trim and clean them by his/her self.</p> <p>Licensed Practical Nurse (LPN) #3 stated in interview conducted on 03/19/14 at 2:00 PM that State Registered Nurse Aides (SRNAs) were to clean/cut nails if the resident did not have Diabetes or thick nails, every week and as needed, and stated the nurses were to monitor and check that nail care had been provided for the residents. LPN #3 acknowledged Resident #2 needed to have nail care provided.</p> <p>Interview with the Clinical Coordinator for the 200 Hall on 03/19/14 at 2:05 PM revealed State Registered Nurse Aides (SRNAs) were to cut and clean nails every week and as needed for those residents that did not have a diagnosis of Diabetes or thick nails; and stated nurses were to cut and clean the nails of those residents with Diabetes. The Clinical Coordinator said Resident #2 did not have a diagnosis of Diabetes and stated the SRNAs should have cut and cleaned Resident #2's nails. The Clinical Coordinator stated supervisors were to monitor for nail care daily, and stated she had not observed that Resident #2 was in need of nail care.</p> <p>SRNA #1 stated in an interview conducted on 03/19/14 at 2:10 PM that staff was to ensure the fingernails/toenails of residents were cut and cleaned on a weekly and as needed basis for those residents that did not have a diagnosis of Diabetes. SRNA #1 stated she had been concerned with shaving Resident #2 and had not</p>	F 312			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 312	Continued From page 15 noticed that Resident #2's fingernails or toenails needed to be cut/cleaned. Interview with the Director of Nursing (DON) on 03/20/14 at 5:10 PM revealed the nurse aides were to ensure resident fingernails/toenails were clean and cut on a weekly and as needed basis. The DON said Supervisors were to observe resident care, including nail care, every two hours to ensure care was provided and stated supervisory staff had not reported concerns related to nail care.	F 312			
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide proper treatment and foot care in accordance with the plan of care for three (3) of twenty-four (24) sampled residents (Residents #4, #17, and #20). According to the care plans for Residents #4, #17, and #20, the residents' toenails were to be kept clean and groomed;	F 328	See attached		

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 328	<p>Continued From page 16</p> <p>however, observations on 03/18/14, 03/19/14, and 03/20/14 revealed staff failed to provide nail care and the residents' toenails were long and unkempt.</p> <p>The findings include:</p> <p>1. Review of the medical record revealed the facility admitted Resident #4 on 02/07/13 with diagnoses including Multiple Spinal Fractures, Hypertension, Arthritis, Extensive Peripheral Vascular Disease, and History of right Femoropopliteal By-pass.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 03/07/14, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident's cognition was severely impaired. In addition, the resident was assessed to require extensive assistance of one staff person for personal hygiene needs and to require total assistance of two staff persons for bathing. According to the resident's comprehensive care plan, the facility assessed the resident to require assistance with self-care and developed interventions that included keeping the resident's nails clean and groomed.</p> <p>Resident #4 was observed on 03/18/14, at 11:30 AM in bed, positioned on his/her back, with bilateral fall mats on the floor. During a skin assessment conducted on 03/18/14, at 3:30 PM, with Licensed Practical Nurse (LPN) #7 and Registered Nurse (RN) #2, the resident's left great toenail was observed to be long and thick and the remaining toenails of both feet were long and in need of trimming/grooming.</p>	F 328			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 328	<p>Continued From page 17</p> <p>Interview with LPN #7 on 03/18/14, at 11:35 AM revealed she had not seen Resident #4's feet in "a while" but did not recall the toenails being "that" long. LPN #7 stated the nurses were responsible to contact the resident's physician for a podiatry consultation when a resident's toenails were difficult to trim due to being long and thick. The LPN stated she didn't know when Resident #4 had been seen by the podiatrist.</p> <p>Interview conducted with State Registered Nurse Aide (SRNA) #6 on 03/20/14, at 2:30 PM revealed she was routinely assigned to Resident #4 each week. SRNA #6 stated she could not recall when she had trimmed Resident #4's toenails, but stated she didn't believe she had provided nail care since December 2013. The SRNA also stated she had reported the thickened toenails to the nurse, but could not recall the nurse's name.</p> <p>Interview with SRNA #7 on 03/20/14, at 3:10 PM, revealed the nurse aides were responsible to provide nail care for Resident #4. However, the SRNA stated the resident's great toenail was too thick to cut and the resident's toenails had "been that way" since the resident was admitted to the facility. SRNA #7 also stated she had reported the resident's thick and long toenails to the nurse, but could not recall which nurse.</p> <p>Interview with LPN #5 on 03/20/14, at 4:15 PM revealed she was the Clinical Coordinator for the 100 Hall and was responsible to ensure resident care needs, including nail care, were provided. LPN #5 stated assigned rounds were conducted daily by the department managers and nail care was to be assessed during the rounds. LPN #5 stated she was not aware the resident's toenails</p>	F 328			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 328	<p>Continued From page 18</p> <p>were thick and long. In addition, the LPN stated no one had reported any problems related to not being able to trim the resident's toenails or the need for a referral to the podiatrist.</p> <p>Interview with the Director of Nursing (DON) on 03/20/14, at 5:10 PM, revealed the nurses were responsible to monitor the condition of the residents' toenails and to notify the attending physician when a podiatry referral was needed. The DON stated a podiatry referral should be provided when the nurse aides or nurses were unable to trim the residents' toenails.</p> <p>2. A review of Resident #17's medical record revealed the resident had diagnoses that included Anemia, Diabetes, history of a stroke, and Dementia.</p> <p>A review of Resident #17's care plan revealed the facility identified that the resident had a self-care deficit and was dependent on staff for Activities of Daily Living (ADL). The facility developed an intervention to "keep nails clean and groomed."</p> <p>Observation and interview with Resident #17 on 03/19/14 at 3:25 PM with an SRNA revealed the resident's right great toenail was long, thick, and growing in toward the resident's second toe. The skin on the second toe of the right foot was observed to be red where the nail on the great toe rested on the second toe. The toenails of the second, third, and fifth toes of the right foot were thick and long. Further observation revealed the left great toenail was thick and long and the toenail was observed to be grown out and back over the base of the toenail. Observation revealed the second and third toenails of the left foot were also long. Further observation revealed</p>	F 328			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 328	<p>Continued From page 19</p> <p>the resident voiced pain during the observation of the feet when the SRNA touched the resident's toenails. Resident #17 stated his/her toes were painful and his/her toenails had not been trimmed since residing at the facility.</p> <p>Interview with LPN #2 on 03/20/14 at 3:19 PM revealed she conducted skin assessments, but Resident #17 frequently refused to let her look at his/her feet. LPN #2 stated she was not aware the resident's toenails "looked like that."</p> <p>Interview with SRNA #1 on 03/20/14 at 1:30 PM revealed Resident #17 threatened to kick the SRNA in the face when she attempted to touch his/her toenails. SRNA #1 stated the resident's nails had been that way ever since she had taken care of the resident. The SRNA further stated it had "been a while" since she had told a nurse about his/her nails.</p> <p>Interview with SRNA #4 on 03/20/14 at 1:26 PM revealed Resident #17's toenails had "been like that a while." SRNA #4 stated nursing assistants did not trim Resident #17's toenails because the resident was diabetic, but had reported to nursing staff that the resident's toenails needed attention.</p> <p>Interview with LPN #2 on 03/19/14 at 2:23 PM, with LPN #3 on 03/19/14 at 2:43 PM, and with LPN #4 on 03/19/14 at 2:58 PM, revealed that nurses were required to provide nail care for diabetic residents. LPN #2 stated nail care was provided one day per week, mostly on Sundays, and documented on the resident's treatment record. Further interview revealed a resident needed to see a podiatrist when nails were thick; toes were red, painful, inflamed; and/or ingrown.</p>	F 328			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 328	<p>Continued From page 20</p> <p>Interview with the Clinical Coordinator for the 200 Hall on 03/19/14 at 2:04 PM revealed nurses were required to trim and clean nails of residents with a diagnosis of Diabetes weekly and as needed, usually on Sundays or on days a skin assessment was required. The Clinical Coordinator stated she monitored residents by performing rounds a few times a day, in random rooms.</p> <p>Interview with the Director of Nursing (DON) on 03/20/14 at 5:07 PM revealed supervisors conducted rounds on residents every two hours to monitor residents' care, including nail care. The DON stated she had not identified any problems with nail care. The DON further stated it was the nurses' responsibility for setting up arrangements for residents to see a podiatrist if needed. The DON stated she had not seen Resident #17's nails in a while. She stated Resident #17 had been to a podiatrist, but could not remember the date. The DON stated she believed the resident would not go back to the podiatrist.</p> <p>3. Review of Resident #20's medical record revealed the resident had diagnoses that included Muscle Weakness, Diabetic Neuropathy, Type 2 Diabetes Mellitus, Dementia, Chronic Obstructive Pulmonary Disease, Degenerative Disc Disease, and Arthritis.</p> <p>A review of Resident #20's care plan revealed the resident had a self-care deficit and was dependent upon staff for activities of daily living (ADL). Further review of the medical record revealed a Treatment Record for Resident #20 for March 2014 with a treatment for "Diabetic Nail Care Weekly per Nurse on Skin Assessment</p>	F 328			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 328	<p>Continued From page 21</p> <p>Days and PRN [as needed]." The Treatment Record had been signed on 03/05/14, 03/12/14, and 03/19/14 indicating the nails were trimmed and cleaned weekly. Review of the weekly skin assessments for Resident #20 dated 03/05/14, 03/12/14, 03/13/14, and 03/19/14 did not indicate that the resident had long toenails.</p> <p>Observation of Resident #20 on 03/20/14 at 1:54PM revealed that the resident had long and thick toenails on all five toes on both the left foot and right foot.</p> <p>Interview with SRNA #9 on 03/20/14 at 1:54 PM revealed that nurses were required to do nail care on residents who had a diagnosis of Diabetes. SRNA #9 stated that she had reported to nurses that Resident #20 had long toenails; however, SRNA #9 stated that she could not remember which nurse she had told about the resident's toenails but stated that she had told "all" of the nurses.</p> <p>Interview with RN #3 on 03/20/14 at 3:13PM revealed that she was responsible for the nail care of residents that were diagnosed with Diabetes. RN #3 stated that she had conducted weekly skin assessments on Resident #20 but had not requested that the resident get an appointment to see a podiatrist in order to get his/her toenails cared for properly. RN #3 stated that she had filed the resident's toenails and stated that she did not know why she had not notified anyone concerning the resident's toenails.</p> <p>Interview with the Clinical Coordinator for the 200 Hall on 03/19/14 at 2:05 PM revealed nurses were required to trim and clean nails for residents</p>	F 328			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 328	Continued From page 22 that had a diagnosis of Diabetes. Interview with the DON on 03/20/14 at 5:17 PM revealed that she was not aware that Resident #20 had long toenails. She stated that the last time she looked at them they were "not bad." She also reported that nursing staff should have reported to her when they identified any resident concerns.	F 328			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	see attached		

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 329	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review it was determined that the facility failed to ensure the drug regimen was free from unnecessary drugs for one (1) of twenty-four (24) sampled residents (Resident #9). Resident #9 received two antipsychotic medications with no documented clinical rationale for why an attempted dose reduction would impair the resident's function or increase distressed behavior.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Consultant Pharmacist Reports," dated May 2007, revealed the consultant pharmacist worked with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendation, and responded to in an appropriate and timely fashion.</p> <p>On 03/19/14 at 2:15 PM, an interview with LPN #1, the Clinical Coordinator, revealed that if the pharmacist felt a Gradual Dose Reduction (GDR) was needed, the pharmacist's recommendations were sent to the resident's physician for review. The physician returned the recommendations to the facility; she reviewed the recommendations and noted any new orders made by the physician.</p> <p>A review of Resident #9's medical record revealed the resident was admitted to the facility on 06/23/06 and had diagnoses that included Dementia with Psychosis and Schizophrenia. A review of Resident #9's Physician Orders</p>	F 329			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 66 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 329	<p>Continued From page 24</p> <p>revealed orders for Paxil (antidepressant) 20 milligrams by mouth daily, Seroquel (antipsychotic) 100 milligrams by mouth at bedtime, and Risperdal (antipsychotic) 0.5 milligrams by mouth every day at 1:00 PM.</p> <p>An interview with LPN #2 on 03/19/14 at 2:23 PM revealed that she had not seen any behaviors from Resident #9 "lately." She stated she knew that the resident took Seroquel and that she thought it was for sleep.</p> <p>An interview with LPN #3 on 03/19/14 at 2:43 PM revealed she was aware Resident #9 was taking medications due to a Schizophrenia diagnosis. She expressed that she had not noticed the resident having any behaviors lately.</p> <p>A review of documentation revealed that the facility pharmacist had contacted Resident #9's physician to ask if the patient would be a candidate for dose reduction for Paxil, Seroquel, and Risperdal on 03/08/13, 08/06/13, and 02/03/14 and the physician indicated that he disagreed with the dose reduction on all three dates. However, the physician failed to provide clinical rationale for continued use of all medications.</p> <p>On 03/19/14 at 2:15 PM, an interview with LPN #1, the Clinical Coordinator, revealed she was responsible for reviewing pharmacy recommendations when they were returned to the facility by the physician. LPN #1 stated that if a physician declined to attempt a gradual dose reduction, she never asked the physician to provide a rationale for continuing usage of the medications. The Clinical Coordinator stated Resident #9 exhibited no behaviors at that time.</p>	F 329			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 85 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 329	Continued From page 25 An interview with Resident #9's physician on 03/19/14 at 3:55 PM revealed the resident had been very agitated in the past and was stable on the current dosage of medications. The physician stated every time a dose reduction had been attempted in the past, it had "not worked." However, there was no rationale documented in Resident #9's medical record for why an attempted dose reduction would impair the resident's function or increase distressed behavior.	F 329			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure the medication error rate was less than 5 percent or greater. Staff was observed to administer medications to residents on 03/18/14. However, based on observation, staff failed to administer two medications to Resident #16 in accordance with physician's orders. The facility's medication error rate was observed to be 6 percent. The findings include: Review of the "Medication Administration Policy" (not dated) revealed medications must be administered by the same person preparing the	F 332	See attached		

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 332	<p>Continued From page 26</p> <p>doses for administration. The policy revealed residents would receive their medications on a timely basis and in accordance with the established policies. The policy further stated medications must be administered within one hour of preparation.</p> <p>Review of Resident #16's medical record revealed physician's orders dated March 2014 for the resident to take 2 puffs of SYMBICORT 160/4.5 micrograms (a medicine for the treatment of asthma and chronic obstructive pulmonary disease), by mouth twice daily at 9:00 AM and 5:00 PM, and then to rinse his/her mouth after use. Further review of the physician's orders revealed the resident was to receive a nebulizer treatment of Iprat-albuterol 0.5-3 mg/3 ml (used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease [COPD]), 1 unit per nebulizer, every 4 hours, and was to use the treatment for 5 minutes at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. According to the physician's order, if the Iprat-albuterol was not available, staff could substitute 2.5-0.5 mg/3 ml "DuoNeb."</p> <p>Observations of a medication pass on 03/18/14 at 4:35 PM revealed Registered Nurse (RN) #1 handed Resident #16 a SYMBICORT 160/4.5 mcg inhaler and the resident properly administered 2 puffs of the inhaler; however, the RN failed to ensure Resident #16 rinsed his/her mouth after the medication was administered as ordered. Continued observation of the medication pass to Resident #16 on 03/18/14 at 4:35 PM revealed RN #1 handed Resident #16 an Iprat-Albuterol (DuoNeb) 0.5-3 mg/3 ml inhaler. Resident #16 took the inhaler and informed the</p>	F 332			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 66 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 332	<p>Continued From page 27</p> <p>RN that he/she would use the inhaler later and placed the vial of medication in the nebulizer machine case for later use. RN #1 then left the room and failed to ensure Resident #16 had used the inhaler as ordered by the physician.</p> <p>Interview with RN #1 on 03/18/14 at 4:40 PM revealed Resident #16 was alert and oriented to time, place, and self, and she felt the resident could self-administer the medications. RN #16 said the nurses could hear the "DuoNeb" machine at the nurses' station and could "tell" when Resident #16 administered the "DuoNeb" treatment. RN #1 said when nurses administered nebulizer treatments, they were to listen for sputum, check the resident's pulse rate, and obtain a pulse oximeter (used to monitor oxygen saturation levels) level before, during, and after using the nebulizer. RN #1 acknowledged she did not obtain the pulse oximeter levels during the treatment or after the treatment for Resident #16. RN #1 further stated that Resident #16 had been instructed on rinsing the mouth after using the SYMBICORT inhaler but was noncompliant with rinsing the mouth. RN #1 acknowledged she had not instructed Resident #16 to rinse the mouth after using the SYMBICORT inhaler on 03/18/14 at 4:35 PM.</p> <p>Interview with Resident #16 on 03/18/14 at 4:50 PM revealed the resident had not been instructed on how or why to rinse his/her mouth after inhaling the SYMBICORT. Resident #16 stated he/she would use the "DuoNeb" treatment before he/she went to smoke after supper.</p> <p>Observation of Resident #16 on 03/18/14 at 6:00 PM revealed the Nebulizer treatment not been administered.</p>	F 332			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 66 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 332	Continued From page 28 Interview with the Clinical Coordinator on the 200 Hall on 03/20/14 at 3:30 PM revealed Resident #16 was not assessed to self-administer medications and RN #1 should have stayed in the room to administer the nebulizer treatment. The Clinical Coordinator further stated RN #1 should have instructed Resident #16 to rinse his/her mouth out after administering the SYMBICORT. Interview with the Director of Nursing (DON) on 03/20/14 at 5:10 PM revealed facility staff had not assessed Resident #16 to be capable of self-medication administration, and stated RN #1 should not have left medications in the resident's room, and the nurse should have encouraged Resident #16 to rinse the mouth after administering the SYMBICORT inhaler. The DON stated she periodically observed medication passes on each shift, on a yearly and as needed basis, to ensure each nurse was competent in medication administration. The DON said there had not been any problems identified with nebulizer treatments or inhalers at the facility.	F 332			

**Barbourville Health and Rehabilitation
Plan of Correction
Annual Survey: March 18-20, 2014**

F 157

1. The physician was notified of Resident #8 recurring redness & drainage of eyes. The Responsible Party was also notified.
2. A review of all residents was completed by Administrative Nursing staff to observe for any change in condition to ensure the physician was notified timely for any changes in resident's physical condition. There were no discrepancies noted.
3. An in-service was conducted with all nursing staff on March 31st, 2014 regarding notification of physician & responsible party with any change in condition in resident status. The in-service included a review of the facility's policy regarding Notification of Change in Condition. Nurse aides were also in-serviced on March 31st, 2014 regarding reporting changes in a resident immediately on an on-going basis.
4. The CQI Committee member designee will complete audit of 5 residents per unit every week for one month then monthly for one quarter. This audit will consist of record review, in addition to direct observation in order to ensure that all changes in condition are being reported to the physician & responsible party timely. Any irregularities will be corrected immediately and reported to the CQI committee for further review and follow-up.
5. Completion Date: April 30th, 2014

**Barbourville Health and Rehabilitation
Plan of Correction
Annual Survey: March 18-20, 2014**

F282

1. Residents #2, #4, #17, & #20 are receiving appropriate nail care & services by nurses per physicians' orders and in accordance with the written plan of care.
2. The plan of care for each resident was reviewed to determine that the resident is receiving care in accordance by their written plan of care by qualified personnel. Additionally, a thorough review of all residents' finger/toenails were completed by Administrative Nursing staff to verify that nail care services were being done or scheduled per physicians' orders in accordance with their written plan of care.
3. An in-service with all nursing staff was conducted on March 31st, 2014 by the Administrative Nursing staff to address the need to ensure that each resident was receiving care in accordance with the residents' written plan of care. Specifically, the procedure for notification of the nurse by SRNA's if a resident need special care for nails (such as podiatry consult, etc), following the resident's individualized plan of care was reviewed. An additional in-service will also be conducted with all nurses and nurse aides on April 25th, 2014 by Administrator & Director of Nursing to review and emphasize the importance of providing care in accordance with the residents' plan of care and reporting to nursing staff any irregularities, such as need for finger/toenail care while providing care.
4. CQI Committee designee (Clinical Coordinators) will conduct random audits of residents' plan of care and make observations to ensure that care is being provided in accordance with the plan of care. This audit will also include the CQI representative completing a review of resident's finger/toenails to verify that any needed care has been done or consult appointment scheduled per physician's orders. These audits will be completed on five residents per unit each week for one month, then monthly for one quarter. Any irregularities will be reported to the CQI committee.
5. Completion date: April 30th, 2014

Barbourville Health & Rehabilitation Center

Plan of Correction

Annual Survey

March 18th-20th, 2014

F 312

- 1. Resident #2 's nails were trimmed and cleaned immediately. Resident #2 is receiving necessary care and services to maintain good grooming and personal hygiene.**
- 2. All resident's nails were checked by the clinical coordinator on each unit to ensure proper nail care was performed. In addition, all residents were observed to ensure they were receiving necessary services to maintain good grooming and personal hygiene.**
- 3. In-services were held with all nursing staff on March, 31st, 2014 by the Administrator and Director of Nursing. The in-service addressed the importance of providing all residents with necessary services to maintain good grooming and personal hygiene. The in-service information also included a thorough review of the nail care protocol and emphasized the importance of nail care.**
- 4. The Clinical Coordinators on each unit will observe five residents weekly for one month and then monthly for the next quarter to ensure all residents are receiving necessary services to maintain good grooming and personal hygiene. Any irregularities will be corrected immediately and reported to the CQI committee for further follow up.**
- 5. Completion Date: April 30th, 2014.**

Barbourville Health & Rehabilitation Center

Plan of Correction

Annual Survey

March 18th-20th, 2014

F 328

1. Resident's #4, # 17, and #20 nails were cleaned, filed and shaped immediately and they are receiving proper treatment and foot care in accordance with the plan of care. Podiatrist appointments were scheduled for all three residents per physician orders.
2. All resident's toenails were assessed by the clinical coordinators on each unit to ensure that all residents are receiving proper foot care in accordance with their plan of care. Nail care was provided to all residents to ensure nails were properly trimmed and groomed as indicated.
3. In-services were held with nursing staff by the Administrator and Director of Nursing on importance of providing proper treatment and foot care in accordance with the resident plan of care. Additionally, the facility protocol on nail care was reviewed and emphasized procedures for nail care. In-service was held on March 31st, 2014.
4. The clinical coordinators on both units will check five resident's toenails weekly for one month and then monthly for the next quarter to ensure all residents are receiving proper treatment and foot care according to plan of care. Any irregularities will be reported to the CQI committee for review and follow up.
5. Completion Date: April 30th, 2014.

Barbourville Health & Rehabilitation Center

Plan of Correction

Annual Survey

March 18th-20th, 2014

F329

1. Resident # 9's physician was contacted immediately to inquire if a dosage reduction could be attempted. Resident # 9's physician refused to reduce her dosage stating, "a dosage reduction had been attempted a while back and it did not work." The physician documented this in a progress note on the medical record.
2. All residents, who receive antipsychotic medications, charts were reviewed to ensure that if the pharmacist has recommended a dosage reduction and the physician does not agree, the physician has provided a rationale as to why he doesn't agree with the dosage reduction and the resident's drug regimen remains free from unnecessary drugs. Any irregularities were called to the appropriate physician.
3. In-services were held with Clinical Coordinators and the nursing staff by Administrator and Director of Nursing regarding policy on pharmacist reviews and gradual dosage reductions to ensure residents' drug regimen is free from unnecessary drugs. In-service was conducted on March 31st, 2014.
4. The CQI Committee designees will conduct audits of pharmacist's recommendations monthly for next quarter to ensure pharmacy recommendations have appropriate documentation of the rationale of the physician if a gradual dose reduction is not attempted and to ensure each resident's drug regimen is free from unnecessary drugs. Any irregularities will be corrected immediately and reported to the CQI committee for further follow up.
5. Completion Date: April 30th, 2014.

**Barbourville Health and Rehabilitation
Plan of Correction
Annual Survey: March 18-20, 2014**

F332

1. The physician for Resident #16 was notified of the occurrences on 3-20-14. Resident #16 is receiving medications as ordered by the physician in a timely manner with special instructions being followed, as indicated.
2. Reviews of the medication pass for all residents have been completed to ensure residents are receiving their medications timely with appropriate instructions i.e. rinse mouth, etc. being followed/instructed, as indicated.
3. An in-service with all nursing staff was completed on March 31st, 2014 by the Administrative Nursing staff to address the need to ensure that each resident is receiving their medications timely as ordered per physician. The in-service also emphasized the importance of following any special instructions that are indicated with medications, and ensuring resident has taken the medication.
4. CQI Committee designee (Clinical Coordinators) will conduct random audits of medication passes to ensure that medications are being given timely, that medications are being taken, and that any special instructions are being followed during medication administration. These medication pass observation/audits will be completed on five residents per unit each week for one month, then monthly for one quarter. Any irregularities will be reported to the CQI committee.
5. Completion date: April 30th, 2014