

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/20/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>550 HIGH ST.</b> <b>BOWLING GREEN, KY 42101</b>	
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F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>An Abbreviated Survey investigating KY20856 was conducted on 10/18/13-11/20/13 to determine the facility's compliance with Federal regulation requirements. KY20856 was substantiated with deficiencies cited at past non-compliance.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of three (3) sampled residents (Resident #1). The facility failed to identify Resident #1 had two (2) Fentanyl (narcotic pain medication) patches on his/her chest when a skin assessment was conducted upon admission, daily for seventy-two (72) hours and weekly thereafter. Resident #1 was admitted to the hospital on 10/11/13 and two (2) Fentanyl patches were found on the resident's chest, one of the patches was dated 09/30/13.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "How to Perform an Accurate Skin Assessment", dated 10/15/13, revealed skin assessments were to be completed upon admission and daily times seventy-two (72) hours on all new admissions. Skin assessments were also to be completed a</p>	F 281	Past noncompliance: no plan of correction required.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>minimum of weekly on all residents, as well as when needed.</p> <p>Record review revealed the facility admitted Resident #1 on 09/30/13 with diagnoses which included Atrial Fibrillation, Coronary Artery Disease, Degenerative Spine Disease, Hypertension, and Polyneuropathy. Review of the initial Minimum Data Set (MDS) assessment, dated 10/07/13, revealed the facility assessed Resident #1's cognition as cognitively intact.</p> <p>Review of the Resident #1's Physician's orders, dated 09/30/13-10/11/13 and the September and October 2013 Medication Administration Records (MAR) revealed a Fentanyl (pain medication) patch was not ordered for Resident #1 when he/she was admitted to the facility or up until the time of transfer the hospital on 10/11/13. Interview with Resident #1, on 10/18/13 at 1:30 PM, revealed no one had placed a Fentanyl patch on him/her since he/she had come to this facility. Interview with Physician #1, on 10/22/13 at 10:11 AM, revealed he did not order Resident #1 any patches on admission or since admission.</p> <p>Review of a Physician's order revealed Resident #1 was transferred to the Emergency Room on 10/11/13 due to the resident being lethargic and difficult to arouse.</p> <p>Review of the Emergency Room Assessment, dated 10/11/13 at 4:01 PM, revealed Resident #1 had a Duragesic (pain medication) patch on when he/she arrived at the hospital.</p> <p>Interview with Hospital Registered Nurse (RN) #1, on 10/23/13 at 11:24 AM, revealed she removed a Fentanyl patch from Resident #1 person when</p>	F 281			

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F 281	<p>Continued From page 2 he/she arrived at the hospital.</p> <p>Interview with Family Member #1, on 10/19/13 at 10:33 AM, revealed a Fentanyl patch with the date of 09/30/13 was found on Resident #1 at the hospital on 10/11/13.</p> <p>Interview with Paramedic #1, on 10/22/13 at 1:00 PM, revealed he identified Resident #1 had two (2) Fentanyl patches on his/her chest in route to the hospital. He stated he removed one of the patches and the Emergency Department staff removed the other patch.</p> <p>Review of the nursing facility's skin assessments for Resident #1, dated 09/30/13, 10/01/13, 10/02/13, 10/03/13 and 10/07/13 revealed no documented evidence the staff identified the resident had two (2) Fentanyl patches on for eleven (11) days he/she was at the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 10/21/13 at 11:24 AM, revealed she completed the initial skin assessment on 09/30/13 and did not remember there being any Fentanyl patches on Resident #1.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/18/13 at 1:25 PM, revealed she completed Resident #1's skin assessment the day after admission and she did not notice a Fentanyl patch on Resident #1.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 10/22/13 at 3:07 PM, revealed Family Member #1 came to the facility on 10/11/13 and told her Resident #1 had a Fentanyl patch on when he/she arrived at the hospital. The ADON stated, an internal investigation was initiated at</p>	F 281			

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F 281	<p>Continued From page 3 that time.</p> <p>Review of the facility's investigation, dated 10/11/13, revealed the facility determined staff failed to conduct thorough skin assessments on Resident #1.</p> <p>Interview with the Administrator, on 10/22/13 at 3:20 PM, revealed the facility staff had not identified the resident had two (2) Fentanyl patches on due to the staff not completing thorough skin assessments.</p> <p>Review of the Performance Improvement Action Plan, dated 10/15/13, revealed the facility took the following actions to correct the deficient practice:</p> <ol style="list-style-type: none"> <li>1. Audit all residents with orders for pain patch to verify pain patch in place and only one patch on with documentation in place.</li> <li>2. Verify count of pain patches of all residents with orders for narcotic pain patches.</li> <li>3. Verify Narcotic E-Kit continues to be counted every shift.</li> <li>4. Disciplinary Actions with 3 licensed nurses for failure to complete head to toe skin assessment.</li> <li>5. 1:1 education with all licensed nurses related to completing head to toe skin assessments per policy.</li> <li>6. Perform three (3) skin assessments per unit per week to validate accuracy of skin assessments x 3 months. The staff was in-serviced about the admission policy and completing a thorough skin assessment on admission and then one skin assessment for the next three (3) days, then weekly or as needed.</li> <li>7. Results will be presented to the Performance Improvement Committee each month x 3 months</li> </ol>	F 281			

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F 281	<p>Continued From page 4</p> <p>to ensure continued compliance or until committee determines compliance has been sustained. This has been incorporated in their QA. All members of the QA, including the Medical Director were involved in the development of Performance Improvement Plan and will be monitored through the QA.</p> <p>The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Review of Resident #2's physician order, dated 02/14/13, revealed to apply a Duragesic/Fentanyl 25 mcg./hr one patch topically and change every three (3) days for pain management.</p> <p>Observation of Resident #2, on 10/18/13 at 1:30 PM, revealed one patch located on the right side of Resident #2's chest. Interview with Resident #2 on 11/20/13 at 10:30 AM revealed that staff removed the old Fentanyl patch off and places a new one on every three (3) days. The site is rotated at this time.</p> <p>Observations of two (2) residents (Resident A and Resident B) and review of the November 2013 MAR on 11/19/13 revealed both residents had one Fentanyl patch on, and they were documented on the MAR.</p> <p>Observation, on 11/20/13, of the narcotic count for three (3) residents in the facility on Fentanyl patches revealed the counts were accurate.</p> <p>Review of the log sheet, on 11/20/13, revealed that the E-Kit continues to be counted every shift.</p> <p>Review of log sheets on 11/20/13, revealed the facility has been completing three (3) skin assessments per week since 10/20/13.</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>Interviews with LPN #6 and LPN #7, on 11/20/13 at 2:52 PM and 3:04 PM respectively, revealed they completed the E-Kit checks and documented on the log every shift. They also completed the three (3) weekly skin audits and logged them on a special log to track them. The LPNs stated they count the narcotic pain patches in the medication carts for each resident every shift.</p> <p>Interviews with RN #1 and RN #2, on 11/20/13 at 3:10 PM and 3:20 PM respectively, revealed E-Kit checks were completed every shift and documented on the log sheet. Pain patches were counted on the carts every shift and when one was placed on a resident. Both RNs stated they completed three (3) weekly skin assessment audits and documented them every week.</p> <p>Review of the disciplinary actions, dated 10/18/13 and 10/19/13 respectively, revealed the three (3) licensed staff who conducted the skin assessments (LPN #1, LPN #7, and LPN #8) received written warnings for failure to follow policies and procedures related to skin assessments. Interviews with the ADON and RN #3, on 11/20/13 at 3:25 PM and 3:33 PM respectively, revealed they had given the written warnings to LPN #1, LPN #7 and LPN #8 and signed the disciplinary actions.</p> <p>A review of the inservice record revealed all licensed staff had been inserviced on the head to toe skin assessment by 10/15/13 and no one was allowed to work until inservicing had been completed. Interviews with Registered Nurse (RN) #1, RN #2, LPN #1, LPN #2, LPN #3, LPN #4, LPN #5, LPN #6, on 10/24/13 at 12:15 PM, 12:21 PM, 12:26 PM, 12:35 PM, 12:37 PM, 12:41</p>	F 281		

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F 281	<p>Continued From page 6</p> <p>PM, 12:45 PM and 12:51 PM respectively, revealed everyone completed inservicing on how to perform a head to toe skin assessment. The inservice included when to complete skin assessments and documentation of the skin assessment. During the inservice, each nurse had to complete a skin assessment on a mannequin. Interview with the ADON, on 10/24/13 at 12:55 PM, revealed licensed staff had completed inservicing on skin assessments. The staff completed an assessment on a mannequin, documented their findings and completed a post test, which was graded. Staff was told they should document everything identified on the skin, not just bruising or wounds. Interview with the Director of Nursing (DON), on 10/24/13 at 1:00 PM, revealed all licensed staff was inserviced on conducting and documenting skin assessments. The staff completed a skin assessment on a mannequin and documented their findings while being critiqued by a preceptor. The staff then took a post test.</p> <p>An interview with the Administrator on 11/20/13 at 12:00 PM revealed the facility's first scheduled PI meeting will be on 11/21/13.</p>	F 281		