

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

PRINTED: 04/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/19/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 F 281 SS=D	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating KY#00018026 and KY#00018032 was initiated on 03/15/12 and concluded on 03/19/12. KY#00018026 and KY#00018032 were substantiated with related deficiencies cited. 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 four (4) sampled residents (Resident #3). The facility failed to ensure Physician's orders were implemented for Resident #3. The Physician ordered Diflucan, 150 milligrams (mg) times three (3) days, on 03/14/12; however, Resident #3 did not receive the first dose until 03/16/12.</p> <p>The findings include: Review of the clinical record revealed the facility admitted Resident #3 on 01/10/12 with diagnoses which included Hypertension, Coronary Artery Disease and Psychosis. Review of the Physician's order, dated 03/14/12, revealed Resident #3 was to receive Diflucan 150 mg every day for three (3) days. Continued review revealed a "Clarification Order", dated 03/16/12, for Diflucan 150 mg every day for three</p>	F 000 F 281	<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>F281</p> <p>Resident #3 received prescribed medication on 3/16/12.</p> <p>On 4/13/12 through 4/25/12, the Assistant Directors of Nursing (ADNS) and Unit Managers (UM) conducted an audit of all inhouse residents' Medication Administration Records (MARs) for April, 2012 to ensure that all ordered medications were administered in a timely manner. Physician and family notification was made for any concerns identified. Appropriate follow-up was conducted with the staff responsible to administer the medication timely.</p> <p>On 4/13/12 through 4/25/12, the Staff Development Coordinator (SDC) and the Weekend Supervisor (WS) conducted education with all licensed nursing staff and all Certified Medication Aides (CMAs)</p>	April 30, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Hallina</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>4/11/12</i>
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A 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	Continued From page 1 (3) days, for a diagnosis of "yeast". Review of the Medication Administration Record (MAR), for 03/12, revealed the order was added to the MAR on 03/15/12. Continued review revealed the first dose was not administered to Resident #3 until 03/16/12. Interview with Licensed Practical Nurse (LPN) #1, on 03/19/12 at 3:15 PM, revealed the order was clarified because the first order did not include the diagnosis. She stated all medication orders must include a diagnosis. She further stated the order should have been clarified with the Physician and the medication should have been initiated on 03/14/12. Interview with the Assistant Director of Nursing for the wing where Resident #3 resided, on 03/19/12 at 5:00 PM, revealed the Difucan should have been administered beginning on 03/14/12 when the initial order was received. He stated all medication orders required a diagnosis for the record, but obtaining it from the Physician should not delay initiation of the drug. He further stated all antibiotics should be given within four (4) hours of receiving the initial order.	F 281	Services Director [SSD], Registered Dietician [RD], Activities Director [AD], Nutrition Services Manager [NSM], Maintenance Director [MD]) monthly for three months and thereafter as needed. The SDC will report medication pass observations to the PIC monthly for 3 months and thereafter as needed. Any corrective action required will be addressed in the PIC. F333 Resident #1 was discharged from the facility on 2/23/12.	April 30, 2012	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the PharMerica Formulary, the facility's resource	F 333	On 4/13/12 through 4/25/12 the Assistant Directors of Nursing (ADNS) and Unit Managers (UM) conducted an audit of all inhouse residents' Medication Administration Records (MARs) for April, 2012 and Meal Intake Records to ensure that all ordered hyperglycemic medications		

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F 333	<p>Continued From page 2</p> <p>for drug administration information, it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident # 1) was free of a significant medication error. The resident's blood sugar was tested at 8:00 AM on 02/23/12. The result was low at 64 mg/deciliter (mg/dL). The resident did not eat breakfast. At 9:00 AM, the nurse administered the daily dose of Glyburide, given to control hyperglycemia (high blood sugar), without determining whether the resident had eaten breakfast. At approximately 12:30 PM, the resident was found to be less responsive and confused. The blood sugar was re-checked and found to be 23. The normal value for the blood sugar level is 74 - 106 mg/dL.</p> <p>The findings include:</p> <p>Review of the PharMerica Formulary, the facility's resource for drug administration information, revealed Glyburide should be administered with meals. Continued review revealed persons who are anorexic (decreased appetite) should have their dose held to avoid hypoglycemia (low blood sugar).</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 02/16/12 with diagnoses which included Congestive Heart Failure, Hypertension and Type II Diabetes.</p> <p>Review of Resident #1's Admission Orders, dated 02/16/12, revealed Resident #1 was to receive the anti-hypertensive drug Glyburide 5 milligrams (mg) every day. Continued review revealed the resident was to have a blood sugar check twice daily, at 6:00 AM and 9:00 PM.</p>	F 333	<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>Services Director [SSD], Registered Dietician [RD], Activities Director [AD], Nutrition Services Manager [NSM], Maintenance Director [MD]) monthly for three months and thereafter as needed. The SDC will report medication pass observations to the PIC monthly for 3 months and thereafter as needed. Any corrective action required will be addressed in the PIC.</p> <p>F333</p> <p>Resident #1 was discharged from the facility on 2/23/12.</p> <p>On 4/13/12 through 4/25/12 the Assistant Directors of Nursing (ADNS) and Unit Managers (UM) conducted an audit of all inhouse residents' Medication Administration Records (MARs) for April, 2012 and Meal Intake Records to ensure that all ordered hyperglycemic medications</p>	April 30, 2012

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F 333	<p>Continued From page 3</p> <p>Review of the Diabetic Monitoring Flow Sheet revealed Resident #1's blood sugar was 64 mg/dL at 6:00 AM on 02/23/12. Review of the Individual Resident Meal Intake Record revealed no consumption for the breakfast meal on 02/23/12.</p> <p>Interview with Registered Nurse (RN) #2, on 03/18/12 at 4:15 PM, revealed she took care of Resident #1 on the morning of 02/23/12. She stated she knew the resident had drunk some juice that morning because of low blood sugar. She further stated she administered Resident #1's Glyburide between 10:00 and 10:30 AM. She stated since no one told her that Resident #1 refused breakfast that morning, she assumed the resident had eaten breakfast and she gave the Glyburide but she shouldn't have done that. Continued interview revealed RN #2 rechecked the blood sugar right after lunch when Resident #1 became less responsive. At that time, the resident's blood sugar was 23 mg/dL. She stated if she had known Resident #1 did not eat breakfast, she would not have given the Glyburide.</p> <p>Interview with the Unit Manager, on 03/16/12 at 9:25 AM, revealed RN #2 should have ensured the resident had eaten prior to administering Glyburide. She stated it was standard practice as a nurse to monitor the blood sugar and meal intake when the resident was prescribed antihyperglycemic medications.</p> <p>Interview with the attending Physician for Resident #1, on 03/15/12 at 2:25 PM, revealed Glyburide could cause decreased blood sugar if the resident had not eaten. She stated it would</p>	F 333	<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>were administered with meals. Physician and family notification was made for any concerns identified. Appropriate follow-up was conducted with the staff responsible to administer the medication appropriately.</p> <p>On 4/13/12 through 4/25/12, the SDC and WS conducted education with all licensed nursing staff and all Certified Medication Aides (CMAs) on appropriate administration of hyperglycemic medications and evaluation of meal intake.</p> <p>The UMs will audit 3 residents MARs and Meal Intake Records per week to validate appropriate administration of hyperglycemic medications. Any concerns identified will have appropriate MD and family notification and follow-up with the staff responsible.</p>	April 30, 2012

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F 333	Continued From page 4 be reasonable for the nurse to ensure the resident had eaten prior to administering Glyburide.	F 333	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	<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> The UMs will report, track and trend audit findings to the PIC monthly for 3 months and thereafter as needed. Any corrective action required will be addressed in the PIC. F431 The facility incurred the cost of the Lortab on 3/1/12. On 4/13/12 through 4/25/12, narcotic physician orders to medication cart audits were conducted by the ADNS', UMs, and SDC of all inhouse facility residents. No other resident was found to have been affected or to have any missing narcotics. A system was developed and implemented for the reconciliation and destruction of all narcotics. This system is the current policy for the center.	April 30, 2012

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F 431	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure a system for identification of loss or diversion of controlled medications, to minimize the time between the actual loss or diversion and the detection of the loss or diversion. A delivery of thirty (30) Lortab tablets was delivered to the facility on 02/18/12, and signed as recieved by the nurse. On 02/24/12, the same nurse reported the pills were not in the narcotic cabinet. The facility could not determine when or how the pills disappeared.</p> <p>The findings include:</p> <p>Review of the policy titled "Ordering and Receiving Schedule III-IV Medications", revealed the facility should prepare a controlled medication accountability record when receiving or checking in a Schedule III, IV or V medication.</p> <p>Review of the Pharmacy Manifest revealed thirty (30) Lortab tablets were delivered on 02/18/12 and accepted by Registered Nurse (RN) #1.</p> <p>Interview with the Unit Manager, on 03/16/12 at 9:25 AM, revealed she became aware on 02/24/12, the Lortab were not in the cart. She stated she began an investigation and discovered the narcotic count sheet with LPN #3's signature was missing from the book as well. Continued interview revealed she forwarded all her information to the Director of Nursing (DON) who took over the investigation. She further stated</p>	F 431	<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>On 4/13/12 through 4/25/12, the SDC and WS conducted inserviceing on the Facility's policy and system changes related to the reconciliation and destruction of all narcotics.</p> <p>Inservice content included:</p> <ul style="list-style-type: none"> Controlled Mediation Policy 62000-02. Pharmerica provides the DNS a copy of the narcotic manifest from the previous day on a daily basis. The DNS maintains a binder with the narcotic manifest, filed by Resident last name. Licensed nurses provide the empty bubble pack or empty narcotic container with the completed Controlled Drug Record, after administration, to the DNS for verification of administration and reconciliation. 	April 30, 2012

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F 431	<p>Continued From page 6</p> <p>she did not know the outcome of the investigation.</p> <p>Interview with RN #1, on 03/19/12 at 3:20 PM, revealed she accepted thirty (30) Lortab from the pharmacy on 02/18/12. She stated she signed the manifest and placed the tablets in the locked drawer in the medication cart. She further stated she placed the signed count sheet in the narcotic book, for reconciliation of the narcotics at every shift change. Continued interview revealed RN #1 recognized on 02/24/12 the Lortab tablets were missing from the cart. The count sheet was missing as well. She stated she remembered, as she was counting all the narcotics, the Lortab should have been there.</p> <p>Interview with the DON, on 03/16/12 at 4:00 PM, revealed she had investigated the missing narcotics. She stated she was unable to determine what happened to them. She reported she had conducted interviews with nursing staff on the unit and identified "poor practice" in the handling of narcotics. She further stated the facility did not require staff to count the sheets and the pills and had no real tracking system, i.e. if a person took the narcotics and the count sheet, no one would ever know they were missing unless they remembered they should be there.</p> <p>Interview with the Pharmacist, on 03/16/12 at 4:05 PM, revealed thirty (30) Lortab, along with the count sheet, were delivered to the facility on 02/18/12. He stated if the drug and the count sheet for a PRN (as needed) medication were both lost or diverted, it may never be discovered unless the resident asked for the medication.</p>	F 431	<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> <ul style="list-style-type: none"> • Within 72 hours after narcotics have been discontinued or the resident is discharged, narcotics and the Controlled Drug Record are submitted to the DNS. • The DNS reconciles all administered, discontinued and/or discharged resident narcotics with the binder containing the narcotic manifest. <p>Nursing Administration will monitor implementation of the policy and the system to validate the reconciliation and destruction of all narcotics through the following steps:</p> <ul style="list-style-type: none"> • UMs will conduct audits of medication carts weekly, for three months, to validate narcotics in the carts match the Medication Administration Records. 	April 30, 2012

This Plan of Correction is the center's credible allegation of compliance.

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.

- On a monthly basis, the DNS will conduct audits of the narcotic manifest and the individual resident Controlled Drug Record to validate narcotics are administered, destroyed and reconciled per policy.

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2012

The UMs and the DNS will report, track and trend audit findings to the PIC three months and thereafter as needed. Appropriate corrective action will be taken as indicated.