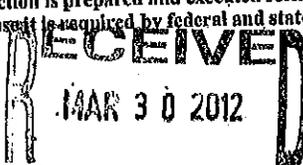


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2012
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#00017932, KY#00017989 and KY#00017997 was conducted 03/07/12 through 03/10/12 with deficiencies cited. KY#00017932 was unsubstantiated with unrelated deficiencies cited. KY#00017989 was unsubstantiated with no deficiencies. KY#00017997 was substantiated with no deficiencies cited.	F 000	Preparation and 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 deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. 	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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.	F 157	F 157 Notification of Changes Criteria 1: -Resident # 2 has expired. -The psychiatry recommendations for resident #2 related to Depakote have been reviewed with the physician, with the MD orders documented on the medical record. Criteria 2: -The last 30 days of 24 hour shift reports have been reviewed for residents demonstrating any signs/symptoms of change in condition, by the DON and ADON on 3/27/12, 3/28/12, 3/29/12, and 3/30/12 to determine that MD notification has been completed and documented. -The last 30 days of psychiatry recommendations have been reviewed by the DON and ADON on 3/27/12, 3/28/12, 3/29/12, and 3/30/12 to determine that the MD has reviewed and responded, and that the response is documented in the medical record.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE, Administrator	(X8) DATE 3/30/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</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> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to consult with the resident's Physician and/or legal representative related to a change in the resident's physical or mental status and/or a need to alter treatment for one (1) of three (3) sampled residents, (Resident #2). The facility failed to provide evidence that Resident #2's Physician was notified regarding a recommendation from the consulting psychiatric Physician to decrease Resident #2's Depakote medication (used to treat Dementia) in September 2011. In addition, the facility failed to notify Resident #2's Physician of an elevated temperature of 101.5 degrees Fahrenheit on 01/06/2012.</p> <p>The findings include: Review of the facility's policy titled, "Notification of Change in Resident Condition", dated 12/21/07 revealed the facility shall notify the attending Physician and representative/sponsor of changes in the resident's medical status. The policy also stated the nursing supervisor/charge nurse will notify the resident's Attending Physician or on-call Physician when there has been a change in baseline vital signs or a need to alter the resident's medical treatment significantly.</p>	F 157	<p>Criteria 3: -Licensed nursing staff have received inservice education on MD notification procedures, including but not limited to: change in condition criteria; reporting of the changes to the MD; reporting of all psychiatry consultant recommendations to the MD; and documentation of the change in condition assessment findings and MD notification in the medical record as provided by the DON/ADON on 3/12/12.</p> <p>Criteria 4: The CQI indicator for the monitoring of MD notification will be utilized monthly X 2 months and then quarterly under the supervision of the DON. This is accomplished by review of the medical record for 5 residents to determine that MD notification and documentation of changes in condition has been completed timely.</p> <p>Criteria 5:</p>	3/30/12

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F 157	<p>Continued From page 2</p> <p>Record review revealed the facility admitted Resident #2 on 11/20/08 with diagnoses which included Dementia with Delusions, Depressive Disorder and Diabetes.</p> <p>1. Review of the "Psychiatric Follow-Up Evaluation" form conducted on 09/10/11 by consulting psychiatric services revealed the recommendation, "TREATMENT PLAN (For any new medications ordered, please obtain informed consent): New Orders - Decrease Depakote 125 mg PO QHS (GDR)" [Depakote one hundred twenty five milligrams (125mg) by mouth (PO) at bedtime (QHS) per the gradual dose reduction, a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose (GDR). However, continued review of the medical record revealed no documented evidence the physician was notified of the recommendation.</p> <p>Interview, on 03/09/12 at 8:10 AM, with Licensed Practical Nurse (LPN) #4, revealed when a recommendation was made for an order change by a consulting Physician the facility should notify the attending Physician of the recommendation to see if the order change should have been implemented. In addition, the information should have been shared with the resident/or the resident's representative.</p> <p>Interview with the Unit Manager, on 03/08/12 at 10:15 AM, revealed no documented evidence the Attending Physician was notified of the recommendation to decrease Resident #2's Depakote medication. Further interview revealed Resident #2's Primary Physician Group should have been made aware of the recommendation.</p>	F 157		

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F 167	<p>Continued From page 3</p> <p>Continued interview revealed the recommendation would then be noted on the "Psychiatric Follow-Up Evaluation" form.</p> <p>2. Record review of Resident #2's clinical record revealed the resident was transferred to an acute care hospital on 01/07/12. Review of the Admission History and Physical, dated 01/07/12, from the acute care hospital revealed the "CHIEF COMPLAINT" included "fever". Continued review revealed Resident #2 was admitted with "Nursing home associated pneumonia and dehydration with acute renal failure..."</p> <p>Interview with Registered Nurse (RN) #2, on 03/09/12 at 5:00 PM, revealed Resident #2 had experienced a temperature above baseline normals on 01/06/12. Continued interview revealed a Certified Nursing Assistant (CNA) had reported to her the elevated temperature and requested she come and check Resident #2. She further stated she recalled Resident #2's temperature to be reported to be above 101 degrees Fahrenheit axillary and therefore requested the supervisor's assistance to assess the resident's condition.</p> <p>Record review of RN #2's employee file revealed Resident #2 had an elevated temperature of 101.6 on 01/06/12 and the employee had been disciplined for failure to notify the Physician.</p> <p>Interview with the Director of Nursing (DON), on 03/09/12 at 7:30 PM, revealed the facility should have notified the Physician and the Resident #2's representative of the elevated temperature on 01/06/12. She further stated there was no documented evidence in Resident #2's chart of</p>	F 167		

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F 157	Continued From page 4 the elevated temperature however she had statements from the CNA supporting Resident #2 had an elevated temperature of 101.5 Farenheit. In addition, she also had statements from the Supervisor which revealed Resident #2 was less alert. Continued interview revealed the facility failed to notify the Physician of Resident #2's change in condition on 01/06/12.	F 157		
F 514 SS-D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain clinical records on each resident in accordance with acceptable professional standards and practices that are complete and accurate as evidenced by failure to document a change in Resident #2's condition which included an elevated temperature of 101.5 degrees Farenheit on 01/06/2012. The findings include:	F 514	F 514 Medical Records Criteria 1: Resident # 2 has expired. Criteria 2: : -The last 30 days of 24 hour shift reports have been reviewed for residents demonstrating any signs/symptoms of change in condition, by the DON and ADON on 3/27/12, 3/28/12, 3/29/12, and 3/30/12 to determine that MD notification has been completed and that the change of conditions assessment findings and MD notification have been documented. Criteria 3: -Licensed nursing staff have received inservice education on MD notification procedures, including but not limited to: change in condition criteria; reporting of the changes to the MD; reporting of all psychiatry consultant recommendations to the MD; and documentation of the change in condition assessment findings and MD notification in the medical record. as provided by the DON and ADON on 3/27/12, 3/28/12, 3/29/12, and 3/30/12.	

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F 514	<p>Continued From page 5</p> <p>Record review revealed the facility admitted Resident #2 on 11/20/08 with diagnoses which included Dementia with Delusions, Depressive Disorder and Diabetes.</p> <p>Review of Resident #2's clinical record revealed the resident was transferred to an acute care hospital on 01/07/12. Review of the Admission History and Physical, dated 01/07/12, from the acute care hospital revealed the "CHIEF COMPLAINT" included "fever". Continued review revealed Resident #2 was admitted to the hospital with "Nursing home associated pneumonia and dehydration with acute renal failure...".</p> <p>Interview with Registered Nurse (RN) #2 on 03/09/12 at 5:00 PM, revealed Resident #2 had experienced a temperature above baseline normals on 01/06/12, the evening before the transfer. Continued interview revealed a Certified Nursing Assistant (CNA) had reported to her the elevated temperature and requested she come and check Resident #2. She further stated she recalled Resident #2's temperature to be reported to be above 101 degrees Fahrenheit axillary and therefore requested the supervisor's assistance to assess the resident's condition.</p> <p>Review of the clinical record revealed no documented evidence of the elevated temperature although record review of RN #2's employee file revealed Resident #2 had an elevated temperature of 101.5 Fahrenheit on 01/06/12 and the employee had been disciplined for failure to notify the physician.</p>	F 514	<p>Criterion 4: The CQI indicator for the monitoring of MD notification will be utilized monthly X 2 months and then quarterly under the supervision of the DON. This is accomplished by review of the medical record for 5 residents to determine that MD notification and documentation of changes in condition has been completed timely.</p> <p>Criterion 5:</p>	3/30/12

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F 514	<p>Continued From page 6</p> <p>Interview with the Director of Nursing, on 03/09/12 at 7:15 PM, revealed she was approached by the family of Resident #2 on 01/09/12 that the resident was at the acute care hospital and very sick. Further interview revealed the DON investigated the events leading up to the transfer of Resident #2 from the facility to the acute care hospital and discovered a CNA had reported the resident's change of condition including the elevated temperature to RN #2 and the Nursing Supervisor.</p> <p>Record review and continued interview with the DON, on 03/09/12 at 7:30 PM, revealed there was no documented evidence in Resident #2's record of the elevated temperature; however, she had statements from the CNA supporting Resident #2 had an elevated temperature of 101.6 Farenheit. In addition, she also had statements from the Supervisor which revealed the resident was less alert. Continued interview revealed she had a statement from RN #2 which supported the elevated temperature. However, record review of the resident's chart revealed no documented evidence including late entries to indicate Resident #2 had a change in his/her condition.</p>	F 514		