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

PRINTED: 04/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Health Survey was initiated on 04/15/14 and concluded on 04/17/14 with deficiencies cited at the highest scope and severity of a "D". A Life Safety Code Survey was initiated and concluded on 04/15/14 with no deficiencies cited.	F 000	*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.*	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to ensure the nursing staff administered medications according to physician orders for one (1) of twenty-four (24) sampled residents, Resident #10. On multiple dates, Resident #10 received an oral medication (Restoril 7.5 mg) without a physician's order. The findings include: Review of the facility's policy titled Physician Orders, revised 11/21/12, revealed physician's orders were administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Routine orders were to	F 309	**F 309 SS=D *Provide Care/Services For Highest Well Being*** **I. How the corrective action will be accomplished for the affected resident:** Resident's (Resident #10), POA (Son) and MD was notified of medication variance by Director of Nursing on 4/17/14. Psychiatric MD and Psychiatric NP were also notified of medication variance on 4/17/14. Licensed Nurse # 2 and Unit Manager were educated on 4/21/14 by Director of Nursing regarding monthly changeover process and verifying transcription of handwritten orders on the (MAR) Medication Administration Record are correct. **II. How corrective action will be accomplished for those residents having potential to be affected:** Nursing Mangers from each unit (Unit Mangers and Center Assistant Director of Nursing) completed from 4/28- 4/30 a review of all Medication Administration Records with the May's monthly change over process and validated all handwritten orders were correct. No other residents were identified to be affected.	5/29/14 5/29/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 5/9/14

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.

RECEIVED
MAY - 9 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

SN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 be entered into the initial admission orders by the nursing staff and entered into the electronic order system for each patient admission. Orders were to be obtained 30 days, 60 days, and 90 days after admission, and every 60 days thereafter. In addition, the staff person transcribing orders onto the Medication Administration Record (MAR) or Treatment Administration Record (TAR) was to ensure the order was signed by the authorized individual, and would ensure there were no transcription errors. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 09/14/13 with diagnoses of Volume Depletion, Osteoarthritis, Anemia, Senile Dementia, Hypertension, Hypercalcemia, and a personal history of falls and kidney injury. Further review revealed Restoril 7.5 mg by mouth, at bedtime to be administered as needed, was ordered upon the resident's admission to the facility. Review of the October MARs revealed Restoril 7.5 mg orally at bedtime, as needed, had been recorded on the MAR, and the medication was administered on 10/04/14, 10/05/14, and 10/09/14. Review of the established patient note, dated 10/23/13, completed by the Advanced Practice Registered Nurse (APRN) for Psychiatric Services, revealed a plan to discontinue Restoril for Resident #10. Review of a physician's order sheet revealed a written order, dated 10/23/13, to discontinue the Restoril. Further review of Resident #10's January and February 2014 MARs revealed a handwritten entry each month for Restoril 7.5 mg orally, at bedtime, as needed. Review of the MARs also revealed Restoril 7.5 mg was recorded as administered eight (8) times in January and	F 309	*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.* **III. What measures will be put in place/systemic changes made to ensure correction:** Every morning all physician orders will be validated for accurate transcription against the Medication Record. Any inaccuracies or errors will be corrected immediately by contacting physician and getting clarification orders and notifying family if necessary. This process will be completed by the Unit Managers for each unit Monday through Friday and the Weekend Supervisor for weekends on Saturday and Sunday. Unit Managers and Weekend Supervisor will review all written medication orders and match them against the medication records for accuracy. Any errors will be correct immediately by contacting Physician and getting clarification orders, and notifying family if necessary. The Director of Nursing will validate process weekly by reviewing all medication administration records books on each unit once a week and randomly select one transcription per week per unit to ensure accuracy of process **IV. How the facility plans to monitor its performance to make sure the solutions are sustained:** All audit results will be reported monthly by the DNS and tracked and trended through	5/29/14 5/29/14

RECEIVED
MAY - 9 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 February 2014 (January 18, 19, 21, 22, 27, 28, and 31, and on February 7). Review of the physician orders for January and February 2014 revealed no order for Restoril 7.5 mg to be given at bedtime as needed. Interview, on 04/17/14 at 2:40 PM, with the East Wing Unit Manager (UM) revealed she was responsible for preparation of the monthly MARs. The Unit Manager stated she reviewed each resident's standard orders, the previous month's MARs/TARs, and any new orders to ensure accuracy of the new month's MAR she prepared for each resident on her hallway. The UM stated the hand written transcription of Restoril 7.5 mg on Resident #10's MAR for February was in her handwriting, but stated she could not determine who had written the as needed Restoril order on the January, 2014 MAR. The UM further stated giving a resident a medication not ordered by the physician could lead to an adverse effect for the resident. Interview, on 4/17/14 at 3:10 PM, with the Medical Records Licensed Practical Nurse (LPN #2) revealed she was responsible for the March 2014 change over and review of the 100 hall MAR/TAR/MD orders. She stated she saw the Restoril 7.5 mg order on the February 2014 MAR and reviewed Resident #10's chart for the original MD order. LPN #2 revealed she found the MD order for Restoril dated 9/14/13 on Resident #10's chart, added the medication to the resident's Physician's Orders for March 2014 and the physician signed the order. She further stated she did not see the Restoril 7.5 mg discontinue order dated 10/23/13. Interview, on 04/17/13 at 1:55 PM, with the	F 309	*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.* the Performance Improvement Committee monthly for the next six months and the frequency of the audits may be increased or decreased based on the findings. The Performance Improvement Committee will continue to monitor findings from the audits until compliance is sustained for six months.	

RECEIVED
MAY - 9 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 Director of Nursing revealed after review of the January MAR/TAR change over, responsibilities were assigned to the East Wing UM. She stated the nurses assigned to the monthly MARs and TARs change-over were expected to review/compare the MAR to the written physician orders on the resident's chart to ensure the accuracy of the MARs/TARs.	F 309	*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.*	
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	F 431	**F431 SS=D Drug Records, Label/Store Drugs & Biologicals:** **I. How the corrective action will be accomplished for affected resident:** 5/29/14 Responsible Unit Manager has been educated on responsibilities and expectations of checking unit refrigerators on 4/21/14 by the Director of Nursing. All expired items found in refrigerator: vacutainers, specimen kits, and medication bottles were removed and destroyed on 4/17/14 by the Unit Manager of unit. No resident was identified to be affected. **II. How corrective action will be accomplished for those residents having potential to be affected:** 5/29/14 All medication refrigerators were audited on all units on 4/17/2014 to ensure all items were current and expiration dates were good. No other medication found to be expired. **III. What measures will be put in place/systemic changes made to ensure correction:** 5/29/14 Reviews of the refrigerators will be performed three times per week by unit managers and one time during week by Director of Nursing. Any deficient practice	

RECEIVED
MAY - 9 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure expired drugs and biologicals were discarded for one (1) of three (3) halls. The East Hall medication refrigerator had eight (8) expired Vacutainers, two (2) expired specimen kits and two (2) expired bottles of Prilosec available for use. The findings include: Review of the Medication Management Policy, dated 02/28/14, revealed medications would be stored appropriately according to the manufacturer's guidelines. Medications and treatment supplies would not be used beyond their expiration dates. Review of the Storage and Expiration of Medications, Biologicals, Syringes and Needles Policy, dated 12/01/07, revealed the facility should ensure that medications and biologicals have an expiration date on the label and the medication had not been retained longer than recommended by the manufacturer or supplier. Observation of the East Unit medication refrigerator, on 04/16/14 at 9:30 AM, revealed there was one (1) male urethral specimen collection kit expired on 12/31/13, 106 days	F 431	*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.* to be corrected immediately and education to occur. The findings will be reported to director of nursing. Director of Nursing will report findings to Performance Improvement Committee and will be tracked and trended for the next six months. **IV. How the facility plans to monitor its performance to make sure the solutions are sustained:** All audit results will be reported monthly by the DNS and tracked and trended through the Performance Improvement Committee monthly for the next six months and the frequency of the audits may be increased or decreased based on the findings. The Performance Improvement Committee will continue to monitor findings from the audits until compliance is sustained for six months.	5/29/14

RECEIVED
MAY - 9 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 5 before the survey. One (1) Endocervical specimen kit expired on 11/30/13, 137 days before the survey. Eight (8) Lesion Diagnostic Vacutainer's expired on 02/28/14, 47 days before the survey and two (2) bottles of Prilosec expired 02/08/14, 68 days before survey. Interview with Licensed Practical Nurse (LPN) #1, on 04/16/14 at 9:40 AM, revealed she had worked night shift before and remembered some of her job duties were to check the refrigerator for temperatures, but not expiration dates. LPN #1 stated she also checked her medication cart for expiration dates. She had never been told to check the refrigerator for expired medications or biologicals. LPN #1 was not sure who was responsible for checking the refrigerator for expired medications. Interview with the Unit Manager of the East Wing, on 04/16/14 at 9:45 AM, revealed all licensed nurses were responsible to ensure the refrigerator was free of expired medications and biologicals. The Unit Manager stated she checked the medication refrigerator once a week; however, she was just looking in a hurry and was not looking for expired dates. The Unit Manager stated if the medications and biologicals were used, the desired affect or potency could be affected. It could make the resident sick, the medication or biological may not work at all, and cause an adverse affect to the resident if used. Interview with the Director of Nursing (DON), on 04/16/14 at 9:44 AM, revealed the Unit Managers and Licensed nurses were responsible for checking the refrigerator. The DON stated the Unit Managers should be checking the refrigerators weekly and when they check the	F 431		

RECEIVED
MAY - 9 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 6 refrigerator they should be checking for expired and discontinued medications. The DON stated if a resident was to use the medication or biological, it could cause an adverse reaction.	F 431		

RECEIVED
MAY - 9 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

RECEIVED
MAY - 7 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

PRINTED: 04/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED
	185196		04/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1960, 1962, 1988 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story with a partial basement; Construction Type III, Unprotected. SMOKE COMPARTMENTS: Ten (10) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system. GENERATOR: Type II, 350 KW generator. Fuel source is diesel. A standard Life Safety Code Survey was conducted on 04/15/14. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5/7/14

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.

SN