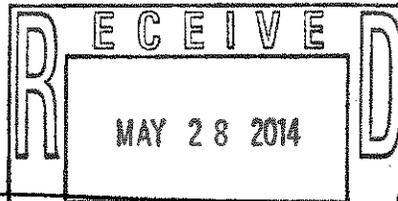


From:

05/28/2014 12:02

#215 P.002/018



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

PRINTED: 05/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING Southern Enforcement Branch B. WING	Division of Health Care C 04/23/2014	
NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
(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 An abbreviated standard survey (KY21543) was initiated on 04/09/14 and concluded on 04/10/14. The investigation was reopened on 04/22/14 and concluded on 04/23/14. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "E" level. The investigation of KY21602 was initiated on 04/22/14 and concluded on 04/23/14. The complaint was unsubstantiated.	F 000	<i>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein</i>		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's policy it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality for two (2) of three (3) sampled residents (Residents #1 and #2). The facility failed to administer medications in accordance with the transferring physician's orders for newly admitted residents. Resident #1 was admitted to the facility with transfer orders to receive Vitamin E 1000 international units daily. The medication was not transcribed correctly from the resident's transfer orders and was not administered to the resident. Resident #2 was admitted with transfer orders for scheduled pain medication Norco 5/325 milligrams to be administered for pain every four hours. The medication order was not transcribed correctly and the pain medication was	F 281	Resident 1 Vitamin E was not transcribed to the MAR upon admission. Director of Nursing informed physician of the error. Patient has discharged from facility before the discovery. Physician informed Director that the patient suffered no ill effect from the error Resident 2 Scheduled pain medication was not transcribed to the MAR. Physician was notified of the error. The order was correctly transcribed to the MAR Resident was placed on alert charting for pain assessment q shift for three days. 483.20(k)(3)(i)-Quality of Life. The facility maintains that services provided or arranged by the facility meet professional standards of quality. How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: The Director of Nursing Services and the MDS Coordinator will meet with the Administrator to review the facility protocols regarding resident assessment including policies and practices to ensure that services provided or arranged by the facility meet professional standards of quality. The Administrator will ensure that the facility policy and practices are consistent with the requirements stated in the regulations. The Directors of Nursing Services and Staff Development and the MDS Coordinator will meet to review the needs of individuals affected by the deficient practice. The Director of Nursing Services will ensure that services provided or arranged by the facility meet professional standards of quality.	5/27/14	

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

TITLE
J. E. Docket
DATE
5-27-14

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.

From:

05/28/2014 12:03

#215 P.003/018

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

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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	
(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 281	<p>Continued From page 1 not administered to the resident as ordered.</p> <p>The findings include:</p> <p>Review of a facility policy related to admission medications, Policy 4.1, revised 01/01/12, revealed the facility should ensure that all medication orders were written, dated, and signed by the physician. Further review of the policy revealed the facility should reconcile transfer and admission orders before the orders were communicated to the pharmacy.</p> <p>The facility did not have a written policy on transferring/transcribing admission orders; however, interview with the Director of Nursing (DON) on 04/23/14 at 2:30 PM revealed the practice in the facility was for the admitting nurse to transfer the orders from the hospital discharge paperwork to a physician's order sheet for the physician to sign. According to the DON, this process was completed by the admitting nurse and no one else checked to ensure the orders were transcribed correctly.</p> <p>1. Review of Resident #1's closed record revealed the facility admitted the resident on 02/24/14 from another facility with diagnoses that included a Surgically Repaired Right Hip Fracture, Atrial Fibrillation, Hypertension, and a Vitamin D deficiency.</p> <p>Review of Resident #1's transfer medication orders dated 02/24/14, revealed the resident was routinely taking Vitamin E 1000 units daily in the evening.</p> <p>Review of the admission orders written for Resident #1 after the resident arrived at the</p>	F 281	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The Directors of Nursing Services and Social Services/Designee will ensure that services provided or arranged by the facility meet professional standards of quality. The Director of Nursing Services will be informed of any delays in obtaining accurate data, completing the assessment and developing the plans of care in a timely manner. The Director of Nursing Services will act upon this information as necessary.</p> <p>The Director of Nursing Services will obtain a record audit from the records department staff of recent resident services provided or arranged by the facility meet professional standards of quality.</p> <p>The Director of Social Services/Designee will be available to attend Resident Council and/or meet with individual residents or their representatives upon request.</p> <p>The Director of Social Services/Designee will establish and maintain relationships with the residents and their family members, representatives and significant others in order to ensure the accuracy of the resident assessments and that care plans meet the needs of the residents.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>This plan will be implemented and the corrective action evaluated for its effectiveness.</p> <p>This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program.</p> <p>The Management Practices Subcommittee, of the Quality Assurance Performance Improvement committee, chaired by the Director of Nursing Services, shall review the accuracy of assessment data on a quarterly basis to ensure compliance.</p> <p>Responsible: Director of Nursing Services.</p>	

From:

05/28/2014 12:03

#215 P.004/018

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/23/2014
NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
(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 281	<p>Continued From page 1</p> <p>not administered to the resident as ordered.</p> <p>The findings include:</p> <p>Review of a facility policy related to admission medications, Policy 4.1, revised 01/01/12, revealed the facility should ensure that all medication orders were written, dated, and signed by the physician. Further review of the policy revealed the facility should reconcile transfer and admission orders before the orders were communicated to the pharmacy.</p> <p>The facility did not have a written policy on transferring/transcribing admission orders; however, interview with the Director of Nursing (DON) on 04/23/14 at 2:30 PM revealed the practice in the facility was for the admitting nurse to transfer the orders from the hospital discharge paperwork to a physician's order sheet for the physician to sign. According to the DON, this process was completed by the admitting nurse and no one else checked to ensure the orders were transcribed correctly.</p> <p>1. Review of Resident #1's closed record revealed the facility admitted the resident on 02/24/14 from another facility with diagnoses that included a Surgically Repaired Right Hip Fracture, Atrial Fibrillation, Hypertension, and a Vitamin D deficiency.</p> <p>Review of Resident #1's transfer medication orders dated 02/24/14, revealed the resident was routinely taking Vitamin E 1000 units daily in the evening.</p> <p>Review of the admission orders written for Resident #1 after the resident arrived at the</p>	F281	<p>Audits were performed on patients admitted or readmitted to the facility for the past ninety days to determine accurate transcription of medication to the MAR. Any errors on admission, if any, were corrected. The result of the entire audit reviewed by the QA Committee for deficient practice and appropriate response from the committee. All new patients being admitted to the facility will be admitted per the Admission Protocol/Policy Statement as Follows:</p> <p>Admission Protocol</p> <p>Policy Statement</p> <p>Stanton Nursing and Rehabilitation maintains a practice that prepares the resident to adjust to the new living environment upon admission.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> Residents being admitted to Stanton Nursing and Rehabilitation (facility) will have an admission plan of care developed meeting state and federal guidelines. The plan will be developed in conjunction with the Director of Nursing/designee, Social Worker, Therapy (as appropriate) Activities Director, Dietary Manager and the resident and/or family member or those legally appointed to fulfill the function of making medical decisions for resident. The admission process begins with the review of the discharge orders from the referring facility and/or physician. The orders will be reviewed by the admitting nurse for accuracy. Errors will be corrected immediately and before the patient is admitted to the facility. Errors which cannot be corrected immediately will result in the admission being suspended until the errors are corrected; the admitting nurse will contact the referring facility and/or Doctor informing them of the errors and the suspended admission. The nurse will work with the facility and/or Doctor to resolve the errors. Suspension of the admission is lifted when all errors are corrected. Patient is taken to the assigned room and placed in bed. The admitting nurse will provide the transcribed physician orders to another duty nurse for review before contacting the physician. The admitting nurse will complete following: <ul style="list-style-type: none"> • Skin Assessment • Establish a Braden Scale Score • Complete a Pain Assessment • Fall Assessment • Confirm Advance Directives • Insert copy of permission to treat on the patient chart that has been completed • Determine Equipment needs / Lab/ • Other issues addressed and completed • Order Medication and confirm availability of same • Complete personal inventory sheet and place on medical record • Complete electronic note summarizing admission • Comfort patient and provide food or drink as appropriate <p>All Licensed Nurses, Social Services, Admissions and MDS Nurses involved in the Admission process have been educated on the Admission Policy. The attached policy is ongoing with no end date.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2014
NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	
(A4) 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 281	<p>Continued From page 2</p> <p>facility on 02/24/14 revealed no evidence the Vitamin E 1000 units was transcribed from the transfer physician orders to the facility's admission orders; the resident did not receive this medication. Additional review of the Medication Administration Records from 02/24/14 until the resident was discharged on 04/04/14 revealed the facility did not administer the medication while at the facility, a period of 38 days.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 04/10/14 at 9:05 AM revealed when Resident #1 was admitted to the facility, the RN reviewed the transfer documentation which included the resident's medications, contacted the physician, and wrote orders for the resident's medications. However, the RN stated she had overlooked the resident's Vitamin E order on the transfer documentation and the medication was never ordered for the resident.</p> <p>Interview with Resident #1's Physician on 04/10/14 at 9:30 AM revealed the Physician was not aware Resident #1 had not received the Vitamin E. According to the Physician, there were no ill effects from not taking the medication.</p> <p>2. The facility admitted Resident #2 on 04/07/14 with diagnoses that included a Surgically Repaired Left Hip Fracture, Difficulty Walking, and Depression.</p> <p>Review of the discharge instructions for Resident #2 revealed orders for Norco 5/325 milligrams (mg) (a medication for pain) to be administered every four hours, and for Norco 5/325 mg, one to two tablets, to be administered every four hours as needed.</p>	F 281	<p>The facility will monitor to ensure that medications are administered in accordance with physician orders by conducting chart audits. Chart audits will be completed by Director of Nursing, Unit Managers and Medical Records. No less than twenty five audits will be completed each seven days until July 31, 2014. Audit results will be directed to the Quality Assurance Committee. The Quality Assurance committee will. Review the audits for deficient practice and take appropriate response.</p> <p>All new admissions will have medications reviewed daily by the Quality Assurance Committee to ensure accuracy to the physician orders.</p>	

From:

05/28/2014 12:04

#215 P.006/018

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/23/2014
NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
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F 281	<p>Continued From page 3</p> <p>Review of Admission Orders for Resident #2 revealed the pain medication Norco 5/325 mg every four hours was not transcribed onto the facility's admission orders. There was no evidence the scheduled pain medication had been ordered by the facility.</p> <p>Review of the medication record for Resident #2 revealed Norco 5/325 mg had been administered to Resident #2 seven times "as needed," when the resident had complained of pain. There was no documentation the resident's pain was assessed prior to administering the medication and the effectiveness of the medication was not assessed until 04/09/14 at 9:00 PM. There was no documented evidence Resident #2 received 12 doses of the Norco 5/325 mg medication from 04/07/14 to 04/10/14, a period of three days as ordered by the transferring physician.</p> <p>An interview conducted with Resident #2 on 04/23/14 at 2:30 PM, revealed the resident was transferred to the facility from a hospital for therapy services. The resident stated staff administered pain medications when requested by the resident and the resident's pain improved after receiving medication. The resident stated he/she thought the pain medication was "supposed to be scheduled."</p> <p>An interview conducted with RN #2 on 04/10/14 at 8:05 AM revealed the RN had transcribed the orders from the discharge summary and notified the physician regarding Resident #2's medication on 04/07/14; however, she did not realize the resident was supposed to have scheduled pain medication. RN #2 did not relay the information to the physician and the medication was not ordered to be given to the resident every four</p>	F 281			

From:

05/28/2014 12:04

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

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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
(A4) 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 281	Continued From page 4 hours. An interview on 04/23/14 at 9:15 AM conducted with the Advanced Practice Registered Nurse (APRN) who had evaluated Resident #2 on 04/07/14 after the resident was admitted to the facility, revealed the APRN thought the resident was on scheduled medications but the APRN had not checked the transcribed orders.	F 281 F284	483.20(l)(3)-Quality of Life. Resident #1 was discharged home. Social Services and Unit Mangers have been in serviced on the discharge procedure by the Director of Nursing and Administrator. A thirty day follow up was completed on resident. The resident is reported doing well and thanked the facility for the care and services provided. Social Services provided contact information to resident in the event She needed to contact the facility in the future.		
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Discharge Policy, it was determined the facility failed to ensure a Discharge Plan of Care was developed to assist the resident to adjust to his/her new living environment. Resident #1 was discharged from the facility and the facility failed to ensure medications were arranged for the resident and failed to ensure a referral to a home health agency was conducted. The findings include: Review of the facility's Discharge Policy dated 07/01/09, revealed in the event a resident was discharged from the facility, the facility would arrange for appropriate continuing care in the				

5/27/14

From:

05/28/2014 12:04

#215 P.008/018

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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
(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)	(X6) COMPLETION DATE	
F 281	Continued From page 4 hours.	F 281			
F 284 SS=D	<p>An interview on 04/23/14 at 9:15 AM conducted with the Advanced Practice Registered Nurse (APRN) who had evaluated Resident #2 on 04/07/14 after the resident was admitted to the facility, revealed the APRN thought the resident was on scheduled medications but the APRN had not checked the transcribed orders.</p> <p>483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Discharge Policy, it was determined the facility failed to ensure a Discharge Plan of Care was developed to assist the resident to adjust to his/her new living environment. Resident #1 was discharged from the facility and the facility failed to ensure medications were arranged for the resident and failed to ensure a referral to a home health agency was conducted.</p> <p>The findings include:</p> <p>Review of the facility's Discharge Policy dated 07/01/09, revealed in the event a resident was discharged from the facility, the facility would arrange for appropriate continuing care in the</p>	F 284	<p>483.20(l)(3)-Quality of Life.</p> <p>The facility maintains that at the time of planned discharges a post-discharge plan of care is developed with the participation of the resident and the family that will assist the resident to adjust to the new living environment.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:</p> <p>The Directors of Nursing Services and Social Services/Designee will meet with the Administrator to review the facility policies and practices regarding anticipated resident discharges. The facility protocols will ensure that at the time of planned discharges a post-discharge plan of care is developed with the participation of the resident and the family that will assist the resident to adjust to the new living environment.</p> <p>The Administrator will ensure that the facility policy and practices are consistent with the requirements stated in the regulations.</p> <p>The Directors of Nursing Services and Social Services/Designee will meet to review the needs of individuals affected by the deficient practice. The Director of Social Services will ensure that at the time of planned discharges a post-discharge plan of care is developed with the participation of the resident and the family that will assist the resident to adjust to the new living environment. Those discharge summaries lacking the required information will be amended as necessary.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The Directors of Nursing Services and Social Services/Designee will ensure that at the time of planned discharges a post-discharge plan of care is developed with the participation of the resident and the family that will assist the resident to adjust to the new living environment. The Director of Nursing Services will be informed of any delays in completing the summary in a timely manner. The Director of Nursing Services will act upon this information as necessary.</p>		

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From:

05/28/2014 12:05

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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380
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F 284	<p>Continued From page 5</p> <p>community. Further review of the policy revealed it was the resident's right to be provided with sufficient preparation and orientation by the facility to ensure a safe and orderly discharge.</p> <p>Review of the closed medical record for Resident #1 revealed the resident was discharged from the facility on 04/04/14 to go home with family.</p> <p>Review of the facility's discharge instructions, dated 04/14/14, revealed Resident #1 was supposed to be referred to home health and his/her medication prescriptions were to be sent to the local pharmacy.</p> <p>An interview conducted with Resident #1's family on 04/09/14, revealed the home health agency was not aware of any referrals for Resident #1 and the local pharmacy did not receive any information regarding prescriptions for Resident #1's medication when the resident was discharged from the facility.</p> <p>An interview conducted on 04/10/14, at 12:55 PM with the Licensed Practical Nurse (LPN), who discharged Resident #1 from the facility on 04/04/14, revealed the LPN contacted the pharmacy, but could not remember if she had spoken to someone or left a message on a machine.</p> <p>Interview conducted with the local Pharmacist on 04/10/14 at 12:15 PM, revealed the Pharmacy had no record of any communication with the nursing home or any medication request for Resident #1 on 04/04/14.</p> <p>Interview with the facility's Social Worker on 04/10/14 at 12:40 PM, revealed she faxed a</p>	F 284	<p>The Director of Nursing Services will obtain a record audit from the records department staff of recent anticipated resident discharges to ensure that at the time of planned discharges a post-discharge plan of care is developed with the participation of the resident and the family that will assist the resident to adjust to the new living environment. Those discharge summaries lacking the required information will be amended as necessary.</p> <p>The Director of Social Services/Designee will be available to attend Resident Council and/or meet with individual residents or their representatives upon request to provide information and support about facility policy and practices. Specifically, the Director of Social Services will review the policies and practices related to assessment and discharge planning practices.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</p> <p>The facility discharge policy will contain the following definition:</p> <p>"Anticipates" means that the discharge was not an emergency discharge or due to the death of the resident.</p> <p>"Adjust to the living environment" means that the post-discharge plan, as appropriate, describes the preferences of the resident and family regarding care, how the resident and family will access these services, and how care should be coordinated if continuing treatment includes multiple caregivers. The plan should identify specific resident needs after discharge such as personal care, sterile dressings, and physical therapy etc., as well as describe resident/caregiver education needs and ability to meet care needs after discharge.</p> <p>"Post-discharge plan of care" means the discharge planning process includes assessing the continuing care needs of the resident and developing a plan designed to ensure that those needs will be met after discharge from the facility into the community.</p> <p>The Director of Staff Development will meet with the Director of Social Services/Designee to develop a training program to ensure that appropriate facility staff and consultants understand and can describe the procedures for developing and documenting a post-discharge plan of care. Specifically, training will review the requirement to develop a post-discharge plan of care with the participation of the resident and family that will help the resident to adjust to the new living environment.</p>	
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From:

05/28/2014 12:05

#215 P.010/018

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2014
NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	
(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 284	Continued From page 6 referral to the home health agency, and the fax confirmation confirmed the fax was received at the home health agency. Further interview revealed Resident #1's family contacted the facility on 04/10/14 because no one from the home health agency had contacted the family about services. After the family called, the facility's Social Worker followed up with the home health agency and found that the home health agency had not received a referral for Resident #1. According to the Social Worker, she had only communicated the referral with the home health agency by fax and had not called to schedule a referral or talked with anyone at the home health agency about the referral until she was contacted by the resident's family.	F 284	Staff from the records department will audit resident assessments to ensure that at the time of planned discharges a post-discharge plan of care is developed with the participation of the resident and the family that will assist the resident to adjust to the new living environment. The audit findings will be reported to the Director of Nursing Services for further action as necessary. The Director of Social Services/Designee will meet with the Director of Staff Development to develop a tool to be used at the time of admission. The tool will ensure that copies of resident rights are provided and reviewed with the resident at the time of admission. At that time the residents will also be informed that the facility conducts assessments of their needs to develop care plans and completes a discharge summary when a transfer is anticipated. The residents will be informed how to make requests and report problems. The admission tool will also ensure that signed acknowledgement is obtained and filed in the business office with the admission contract.	
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 review of the facility's policy, it was determined the facility failed to ensure one (1) of three (3) sampled residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Resident #2 was admitted to the	F284	An audit was conducted on all patients discharged to home for the last ninety days. The results of that survey were presented to the QA Committee for deficient practice and appropriate response from the committee. All discharged patients, unless excluded by the policy, will be discharged by direction of the policy. The policy has no end date and is ongoing. Discharge Planning Policy Statement Stanton Nursing and Rehabilitation maintains a practice that prepares the resident to adjust to the new living environment upon discharge. Policy Interpretation and Implementation 1. Residents being discharged from Stanton Nursing and Rehabilitation (facility) will have a post-discharge plan of care developed. 2. The plan will be developed in conjunction with the Director of Nursing Designee, Social Worker, Therapy (as appropriate) the resident and family member or those legally appointed to fulfill the function of making medical decisions for resident. 3. The discharge planning meeting will occur within seven days of the planned discharge date but no later than forty eight hours before discharge. 4. The discharge plan will include: • Patient Name • Room Number • Diagnosis • Therapy Evaluation (when applicable) • Nursing Evaluation	

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NAME OF PROVIDER OR SUPPLIER

STANTON NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

31 DERICKSON LANE
STANTON, KY 40380

(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
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F 284

Continued From page 6
referral to the home health agency, and the fax confirmation confirmed the fax was received at the home health agency. Further interview revealed Resident #1's family contacted the facility on 04/10/14 because no one from the home health agency had contacted the family about services. After the family called, the facility's Social Worker followed up with the home health agency and found that the home health agency had not received a referral for Resident #1. According to the Social Worker, she had only communicated the referral with the home health agency by fax and had not called to schedule a referral or talked with anyone at the home health agency about the referral until she was contacted by the resident's family.

F 284

- Assistive Devices/ Equipment needed
 - Availability of equipment confirmed and arranged
 - Patient/Family Education
 - Pain E. situation
 - Home Evaluation done (when applicable)
 - Discharge Plan
 - Physician Discharge orders obtained
 - Medication Arranged
 - Home Health appointment (where applicable)
5. The Director of Nursing will review the Discharge Plan for accuracy and completeness within 24 hours of discharge Errors or omissions will be corrected immediately.
 5. Within seven days of discharge an audit will be conducted by the Medical Records. The Audit results will be provided to the Director of Nursing and Administrator. The Administrator will bring results to the Quality Assurance Committee for review appropriate response and action
 6. Patients leaving against medical advice will be asked to sign an AMA discharge form. Patients leaving against medical advice will not be provided medications etc and will be warned of the risks and dangers regarding their decision to discharge against medical advice. Against Medical Advice discharge will be treated as an anticipated discharge.

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.

Discharge Planning

Policy Statement

Stanton Nursing and Rehabilitation maintains a practice that prepares the resident to adjust to the new living environment upon discharge.

Policy Interpretation and Implementation

The attending physician will be notified of the decision and Adult Protective Services will also be informed of the patient's decision.

Definitions:

- Anticipates means that the discharge was not an emergency discharge, due to the death of the resident or against medical advice
- Adjust to the living environment means that the post discharge plan, as appropriate describes the preferences of the family and resident regarding care, how the family and/or resident will access these services and how care should be coordinated if continuing treatment includes multiple care givers.

The QA Committee will review all admissions regarding the deficient practice. The result of the entire audit reviewed by the QA Committee for deficient practice and appropriate response from the committee. All employees involved in the discharge process have been educated on the Discharge Policy.

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 ensure one (1) of three (3) sampled residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Resident #2 was admitted to the

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F 309	<p>Continued From page 7</p> <p>facility with transfer orders for the resident to receive scheduled pain medication every four hours. The facility failed to transcribe the pain medication order to the facility's admission orders and failed to administer the medication to Resident #2. Resident #2 received the medication when the resident was in pain and requested the medication.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Pain-Clinical Protocol with a revision date of April 2007, revealed upon admission the physician and staff would identify individuals who had pain or were at risk for having pain. Further review of the policy revealed diagnoses and current treatments should be reviewed.</p> <p>Review of the medical record for Resident #2 revealed the facility admitted Resident #2 on 04/07/14, with diagnoses of a Surgically Repaired Left Hip Fracture. Review of the discharge instructions for Resident #2 revealed transfer physician orders for scheduled Norco (pain medication) 5/325 milligrams (mg) to be administered every four hours. The discharge instructions also contained an order for Norco 5/325 mg one to two tablets every four hours prn (as needed) for pain.</p> <p>Review of the facility's admission orders transcribed for Resident #2 revealed the pain medication Norco 5/325 mg had only been ordered for one tablet every four hours as needed. There was no evidence the scheduled pain medication had been ordered.</p> <p>Interview on 04/23/14 at 2:30 PM, with Resident</p>	F 309	<p>483.25 (a) Quality of Care.</p> <p>The facility maintains that the facility provides and the residents receive the care and services necessary to attain or maintain the highest practicable physical, mental and psychosocial status in accordance with their individual comprehensive assessment and plan of care.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:</p> <p>The Directors of Nursing Services and Social Services/Designee will meet with the Administrator to review the facility policies and practices regarding anticipated resident discharges. The facility protocols will ensure that the facility provides and the residents receive the care and services necessary to attain or maintain the highest practicable physical, mental and psychosocial status in accordance with their individual comprehensive assessment and plan of care.</p> <p>The Administrator will ensure that the facility policy and practices are consistent with the requirements stated in the regulations.</p> <p>The Directors of Nursing Services, Staff Development and Social Services/Designee will meet to review the needs of individuals affected by the deficient practice. The Director of Nursing Services will ensure that the facility provides and the residents receive the care and services necessary to attain or maintain the highest practicable physical, mental and psychosocial status in accordance with their individual comprehensive assessment and plan of care.</p> <p>When appropriate, the Director of Social Services/Designee will meet with individual residents to ensure the services, processes and results of care and services provided by the facility are satisfactory with the residents affected by the deficient practice. To the satisfaction of these residents and the facility, the Director of Social Services will resolve issues that may arise in meeting the needs of the residents in coordination with the Director of Nursing Services.</p> <p>How the facility will identify other residents having the</p>	5/27/14	

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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
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F 309	<p>Continued From page 7</p> <p>facility with transfer orders for the resident to receive scheduled pain medication every four hours. The facility failed to transcribe the pain medication order to the facility's admission orders and failed to administer the medication to Resident #2. Resident #2 received the medication when the resident was in pain and requested the medication.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Pain-Clinical Protocol with a revision date of April 2007, revealed upon admission the physician and staff would identify individuals who had pain or were at risk for having pain. Further review of the policy revealed diagnoses and current treatments should be reviewed.</p> <p>Review of the medical record for Resident #2 revealed the facility admitted Resident #2 on 04/07/14, with diagnoses of a Surgically Repaired Left Hip Fracture. Review of the discharge instructions for Resident #2 revealed transfer physician orders for scheduled Norco (pain medication) 5/325 milligrams (mg) to be administered every four hours. The discharge instructions also contained an order for Norco 5/325 mg one to two tablets every four hours prn (as needed) for pain.</p> <p>Review of the facility's admission orders transcribed for Resident #2 revealed the pain medication Norco 5/325 mg had only been ordered for one tablet every four hours as needed. There was no evidence the scheduled pain medication had been ordered.</p> <p>Interview on 04/23/14 at 2:30 PM, with Resident</p>	F 309	<p>potential to be affected by the same deficient practice:</p> <p>The Directors of Nursing Services, Staff Development and Social Services/Designee will review audits from the records department staff to ensure that the facility provides and the residents receive the care and services necessary to attain or maintain the highest practicable physical, mental and psychosocial status in accordance with their individual comprehensive assessment and plan of care. Specifically, the audits will be used to identify other residents who are at risk due to the deficient practice. The Director of Nursing Services will be informed of any delays in obtaining audit information and required evaluations. The Director of Nursing Services and Director of Social Services will act upon the results of the audit as necessary.</p> <p>The Director of Social Services/Designee will be available to attend Resident Council and/or meet with individual residents or their representatives upon request to provide information and support about facility policy and practices. Specifically, the Director of Social Services will review the policies and practices related to the care and services provided by the facility.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</p> <p>The facility policy will include, at a minimum, the following definition and information:</p> <p><input type="checkbox"/> Highest practicable <input type="checkbox"/> is defined as the highest level of functioning and health possible, limited only by the presenting functional status and potential for improvement or reduce rate of functional decline of the individual residents. The highest practicable level is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.</p> <p><input type="checkbox"/> Skin Ulcer/Wound <input type="checkbox"/> definitions are distinguished by the clinical basis of the wound during assessment and diagnosis.</p> <p><input type="checkbox"/> Arterial Ulcer <input type="checkbox"/> is an ulceration that occurs as the result of arterial occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis.</p> <p><input type="checkbox"/> Diabetic Neuropathic Ulcer <input type="checkbox"/> is diagnosed in the presence of diabetes mellitus and peripheral neuropathy.</p> <p><input type="checkbox"/> Pressure Ulcer <input type="checkbox"/> is defined in F-314/ 42 CFR 483.25 (c).</p> <p><input type="checkbox"/> Venous insufficiency Ulcer (also known as a <input type="checkbox"/> stasis ulcer <input type="checkbox"/>) is an open lesion of the skin and subcutaneous tissue to the lower leg, usually occurring in the pre-tibial area of the lower leg or above the medial ankle. They</p>		

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F 309	<p>Continued From page 8</p> <p>#2 revealed the facility admitted the resident from the hospital for therapy services. According to the resident, he/she experienced occasional episodes of hip pain which ranged from 7 to 9 on a pain scale of 1 to 10. Further interview revealed when the resident asked staff for pain medication to be administered, staff administered the pain medications and the pain would improve to a 1 to 2 rating. The resident was concerned regarding the pain medication because he/she was told when discharged from the hospital the pain medication was scheduled every four hours.</p> <p>An interview conducted on 04/10/14 at 8:05 AM, with Registered Nurse (RN) #2 revealed the RN had transcribed the medication orders from the transfer physician orders and notified the physician regarding Resident #2's medication on 04/07/14; however, RN #2 stated she did not realize the resident was "supposed to have scheduled pain medication." RN #2 did not relay the information to the physician and the pain medication was not ordered to be given to the resident every four hours. Further interview with the RN revealed the facility did not have a system where the orders were checked by another staff person.</p> <p>Interview conducted with the Certified Medication Technician (CMT) on 04/22/14 at 3:50 PM, revealed the CMT had administered pain medication to Resident #2 on 04/07/14 at 10:00 PM, and on 04/08/14 at 5:00 PM and 10:00 PM. According to the CMT, the resident rated the pain at 4 to 5 and the pain medication was effective. Further interview revealed the CMT had not documented the pain rating or the effectiveness of the pain medication on a pain flow sheet and could not recall why.</p>	F 309	<p>are considered the most common vascular ulceration.</p> <p><input type="checkbox"/> Vital Signs <input type="checkbox"/> include five categories: blood pressure, pulse, respirations, body temperature and the presence or absence of pain.</p> <p><input type="checkbox"/> Dry Weight <input type="checkbox"/> is defined as the lowest bodily fluid level tolerated by the patient without intradialytic symptoms and hypotension in the absence of fluid overload.</p> <p><input type="checkbox"/> Dysphagia <input type="checkbox"/> is abnormal bolus formation and/or swallowing.</p> <p><input type="checkbox"/> Aspiration <input type="checkbox"/> as a result of dysphagia means that foreign matter entered the lungs. This may lead to infection in the lungs. <input type="checkbox"/> Silent aspiration <input type="checkbox"/> means that the resident displayed no outward symptoms of choking or coughing when food went down the <input type="checkbox"/> wind pipe <input type="checkbox"/> and into the lungs.</p> <p>The Director of Staff Development will meet with the Director of Social Services/Designee to develop a training program to ensure that the facility uses the appropriate definitions when assessing residents.</p> <p>Staff from the records department will audit resident assessments to ensure the facility uses the appropriate definitions when assessing residents. The audit findings will be reported to the Directors of Nursing Services and Staff Development for further action as necessary.</p> <p>The Director of Nursing Services, Staff Development and Social Services/Designee will meet to develop and implement a plan to monitor the care and services provided to the individual residents. As necessary the Director of Nursing Services and Director of Staff Development will intervene with staff to demonstrate and/or direct aspects of the individual plans of care in a manner that ensures that the needs of the residents are met. When the needs of the resident change, the Director of Nursing Services will be advised and ensure that the resident is reassessed and the plan of care revised. The Director of Staff Development will monitor the performance of staff and as necessary, train staff to ensure they have the skills to provide the required care and services. This will be documented. The Director of Nursing Services, Director of Staff Development and Director of Social Services will ensure that staff follows the plans of care for the individual residents. Staff failing to implement the plans of care for the residents will be reprimanded and provided additional training.</p> <p>The Directors of Social Services/Designee and Staff Development will meet with the Director of Admissions to develop a tool to be used at the time of admission. The tool will ensure that copies of resident rights are provided and reviewed with the residents at the time of admission. At that time the residents will also be informed that the facility conducts assessments of their needs to ensure that the resident's needs for care and services are identified and provided by the facility. The residents will</p>		

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F 309	<p>Continued From page 8</p> <p>#2 revealed the facility admitted the resident from the hospital for therapy services. According to the resident, he/she experienced occasional episodes of hip pain which ranged from 7 to 9 on a pain scale of 1 to 10. Further interview revealed when the resident asked staff for pain medication to be administered, staff administered the pain medications and the pain would improve to a 1 to 2 rating. The resident was concerned regarding the pain medication because he/she was told when discharged from the hospital the pain medication was scheduled every four hours.</p> <p>An interview conducted on 04/10/14 at 8:05 AM, with Registered Nurse (RN) #2 revealed the RN had transcribed the medication orders from the transfer physician orders and notified the physician regarding Resident #2's medication on 04/07/14; however, RN #2 stated she did not realize the resident was "supposed to have scheduled pain medication." RN #2 did not relay the information to the physician and the pain medication was not ordered to be given to the resident every four hours. Further interview with the RN revealed the facility did not have a system where the orders were checked by another staff person.</p> <p>Interview conducted with the Certified Medication Technician (CMT) on 04/22/14 at 3:50 PM, revealed the CMT had administered pain medication to Resident #2 on 04/07/14 at 10:00 PM, and on 04/08/14 at 5:00 PM and 10:00 PM. According to the CMT, the resident rated the pain at 4 to 5 and the pain medication was effective. Further interview revealed the CMT had not documented the pain rating or the effectiveness of the pain medication on a pain flow sheet and could not recall why.</p>	F 309	<p>be informed how to make requests and report problems. The admission tool will also ensure that signed acknowledgement is obtained and filed in the business office with the admission contract.</p> <p>At the time of admission residents will be provided a copy and explanation of resident rights. The tool will also ensure that residents are informed of the assessment process and efforts to ensure that the assessment data are accurate. The admission process tool, developed to ensure that specific tasks were completed at the time of admission, will be used.</p> <p>The Director of Social Services/Designee will establish and maintain relationships with the residents and their family members, representatives and significant others in order to ensure the accuracy of the resident assessments and that care plans meet the needs of the residents.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>This plan will be implemented and the corrective action evaluated for its effectiveness.</p> <p>This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program.</p> <p>The Clinical Care Subcommittee, of the Quality Assurance Performance Improvement Committee, shall review the care and services provided by the Interdisciplinary Team on a quarterly basis to ensure compliance.</p> <p>Responsible: Director of Nursing Services.</p>		
			<p>F309</p> <p>All patients residing in the facility have been reassessed for pain with appropriate interventions provided as needed. All the assessments were reviewed by the QA Committee for deficient practice and appropriate response taken. All employees of the facility have been educated on the basic signs of pain from a resident and educated to report the symptoms immediately to the charge nurse. Pain protocol and education material follows:</p>		

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F 309	Continued From page 9 Interview with RN #4 on 04/23/14 at 12:03 PM revealed the RN had administered pain medication to Resident #2 on 04/08/14 at 8:00 AM and 1:00 PM. According to RN #4, Resident #2 rated his/her pain at 5 to 7 on a 1 to 10 scale. When the RN checked on the resident, the resident rated his/her pain at a level of 2. Further interview with the RN revealed she had not documented the findings on the pain flow sheet because a flow sheet may not have been on the resident's medication record. She stated she may have been busy and not put one on the medication record. Review of the pain assessment completed for Resident #2 revealed the resident had a history of pain at a level of 4 on a 1 to 10 scale during the week before being admitted to the facility. Interview conducted on 04/23/14 at 9:15 AM with the Advanced Practice Registered Nurse (APRN) revealed the APRN had evaluated Resident #2 on 04/07/14. The APRN stated she believed the resident was on scheduled medications.	F 30	Pain Assessment and Management Policy Statement Stanton Nursing and Rehabilitation maintains that appropriate knowledge, skills and attitudes towards pain, pain assessment and its management is integral in caring for residents. The facility provides for a systematic process of pain assessment, measurement and re-assessment (re-evaluation) which enhances the health care team's ability to manage pain. Policy Interpretation and Implementation 1. The facility pain management program is used to: <ul style="list-style-type: none"> Reduce the experience of pain by a resident Increase the comfort of the resident Improve the physiological, psychological well being of the resident Improve physical function of the resident Increase satisfaction with pain management from resident) 2. The pain assessment involves: <ul style="list-style-type: none"> Factors that may influence a patient's experience and expression of pain Comprehensive process of describing pain and its effects on function Awareness of barriers that may affect nurse's assessment and management of pain. 3. Measuring Pain requires using an assessment tool that identifies the quantity and or quality of one or more of the dimensions of the patient's experience of pain. This includes intensity of pain and intensity and associated anxiety and behavior 4. Self-reporting (expression) of their pain is regarded as the gold standard of pain Management as it provides the most valid measurement of pain self reporting can be influenced by numerous factors including mood, sleep disturbances, and medications and may result in patients not reporting pain accurately. For example they may fail to report their pain because of the effects of sedation or lethargy and reduced motivation as a consequence of sleep deprivation. Some may suffer in silence as they do not want to bother nurses. 5. Pain assessment tools include both uni-dimensional and multi-dimensional methods Uni-dimensional tools <ul style="list-style-type: none"> Measure one dimension of the pain experience, for example, intensity Are accurate, simple, quick, easy to use and understand Are commonly used for acute pain assessment Have verbal rating scale and the verbal descriptor scales for example, none, mild, moderate, severe Tools: Verbal rating scales, Graphic rating scales, Numerical rating scales verbal descriptor scales body diagrams picture scales 		
			Pain Assessment and Management Policy Statement continued Acute pain Location and description of pain <ul style="list-style-type: none"> Is the pain a primary complaint or a secondary complaint associated with another condition? What is the location of the pain and does it radiate? Describe the onset and circumstances associated with it. How intensely is the pain, for example, at rest, on movement and factors that exacerbate or relieve pain. Describe the character of pain using quality/sensory descriptors for example, sharp, throbbing, burning, burning, stabbing, allodynia (pain associated with gentle touch). How long does the pain last, for example, continuous, intermittent. 		

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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	
(X4) ID PREFIX TAG F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 30	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	<p>Continued From page 9</p> <p>Interview with RN #4 on 04/23/14 at 12:03 PM revealed the RN had administered pain medication to Resident #2 on 04/08/14 at 8:00 AM and 1:00 PM. According to RN #4, Resident #2 rated his/her pain at 5 to 7 on a 1 to 10 scale. When the RN checked on the resident, the resident rated his/her pain at a level of 2. Further interview with the RN revealed she had not documented the findings on the pain flow sheet because a flow sheet may not have been on the resident's medication record. She stated she may have been busy and not put one on the medication record.</p> <p>Review of the pain assessment completed for Resident #2 revealed the resident had a history of pain at a level of 4 on a 1 to 10 scale during the week before being admitted to the facility.</p> <p>Interview conducted on 04/23/14 at 9:15 AM with the Advanced Practice Registered Nurse (APRN) revealed the APRN had evaluated Resident #2 on 04/07/14. The APRN stated she believed the resident was on scheduled medications.</p>		<p>Assessment of functional and medical problems should consider:</p> <ul style="list-style-type: none"> • Symptoms associated with the pain, for example, nausea. This can help to identify an underlying cause for pain and also identify the need for symptom management. • Effect of pain on activities, for example, mobility, sleep. • Medications/treatments and their effect on pain. • Medical and drug history. • Family history. • Psychosocial assessment, for example, anxiety, coping skills, occupation. • Physical examination. • Evaluation of disability associated with the pain. <p>Factors relevant to effective treatment:</p> <ul style="list-style-type: none"> • Patient's beliefs about pain, expectations and preference of treatment. • Coping mechanisms, for example, using distraction techniques such as walking or reading. • Patient's knowledge of pain management techniques and expectation of outcome. • Ability to use appropriate pain measurement tools. • Family expectations and beliefs about pain and the patient's illness. <p>Chronic pain (consider above also)</p> <p>Questions to consider for patients with chronic pain:</p> <ul style="list-style-type: none"> • Was the onset of pain related to trauma or was it insidious? • How long has the patient had pain? • Ask the patient how and why any injury associated with pain occurred? • Where is the pain? (Is there more than one location?) • Does the patient have referred pain? • Is the patient pain free under any circumstances? • What movements make pain worse? • Is there any weather that makes the pain worse? • What relieves pain? • What is the level of pain described by the patient and using an assessment scale? • Is there a pattern to pain when the patient gets up in the morning? Does pain increase as day goes on? This indicated whether the pain gets worse with activity. • What effect do analgesic medicines have on the pain? • Does pain wake the patient? • Does the patient have psycho-physiological responses following severe pain, for example, jittery, nausea, changes in mood? • Ask the patient to describe their pain? • Is there any numbness or loss of muscle strength associated with the pain? • Do normal stimuli make pain worse, for example, light touch, shower? • Is pain tolerable for most of day? <p>Questions about common problems associated with pain</p> <ul style="list-style-type: none"> • Is the pattern of pain unusual? • Is the pain intermittent? • Is the pain chronic? • Does the pain stop the patient carrying out usual activities? • Does the pain have a neuropathic component or elements of complex regional pain syndrome when the patient complains of a chronic burning pain in one limb? • Are there psycho-physiological responses to the pain? <p>Pain Post Education Test</p> <p>Name _____ Date _____</p> <ol style="list-style-type: none"> 1) Non-verbal Behaviors indicating possible pain are Grimacing, Moaning, Restlessness, Anger True False 2) Music Therapy is an effective way to control pain in some instances True False 3) Patients will always report pain to a nurse True False 4) Non Nursing employees can not help with pain management True False 5) The golden rule of pain reporting is report the pain at the end of your shift True False 	

From:

05/28/2014 12:09

#215 P.018/018

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

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F 309	Continued From page 9 Interview with RN #4 on 04/23/14 at 12:03 PM revealed the RN had administered pain medication to Resident #2 on 04/08/14 at 8:00 AM and 1:00 PM. According to RN #4, Resident #2 rated his/her pain at 5 to 7 on a 1 to 10 scale. When the RN checked on the resident, the resident rated his/her pain at a level of 2. Further interview with the RN revealed she had not documented the findings on the pain flow sheet because a flow sheet may not have been on the resident's medication record. She stated she may have been busy and not put one on the medication record. Review of the pain assessment completed for Resident #2 revealed the resident had a history of pain at a level of 4 on a 1 to 10 scale during the week before being admitted to the facility. Interview conducted on 04/23/14 at 9:15 AM with the Advanced Practice Registered Nurse (APRN) revealed the APRN had evaluated Resident #2 on 04/07/14. The APRN stated she believed the resident was on scheduled medications.	F 309	6) Medications always help patients report pain more accurately True False 7) Pain Management program is designed to help the employee hear less complaining from residents about pain True False 8) A resident who did not sleep well over several days due to pain will report their pain to the nurse as soon as possible True False 9) A resident exhibiting unusual anxiety may be experiencing increased pain True False 10) A change in vital signs may indicate an increase in pain True False 11) Residents are the most reliable source for identifying pain True False 12) Silence by the resident is a strong indication that pain does not exist True False 13) Irritability could be an indicator of resident pain True False 14) Old people get pain and there is nothing that can be done about it True False 15) I must report any signs of suspected pain in a resident to the Nurse Supervisor immediately True False Pain assessments are being done Q shift. Patients requiring interventions are reviewed by the QA Committee for deficient practice with appropriate response taken. The Pain Management Protocol is ongoing with no end date. All staff has been trained to recognize pain in residents by Director of Nursing. All nurses have been re educated on recognizing pain in non verbal residents and also have been reeducated on assessing pain before and after administering pain medication. Licensed Nurses have been reeducated to follow physician orders on administering pain medications and notifying physician in the event of uncontrolled pain. Training was completed by the Director of Nursing and Administrator on the following dates: May 15, May 16, May 17, and May 12. The Quality Assurance Committee reviews pain assessments audits on a daily basis for deficient practice and takes appropriate response. Review will continue until July 31, 2014. The members of the Quality Assurance Committee consist of The Administrator, Director of Nursing, Unit Managers, Rehab Coordinator, Dietary Manger, Activities Director, MDS Coordinator and Medical Records.		