

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

PRINTED: 04/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2014
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141		
(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	F 000			
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review</p>	F 329	<p>F 329 Unnecessary Drugs</p> <p>Each resident's drug regimen must be free from unnecessary drugs.</p> <p>Criteria 1: The drug regimen for resident #9 has been reviewed by the consulting Pharmacist, Psych consultant, and MD with medication changes completed and rational documented for the use of the current psychotropic medications.</p> <p>Criteria 2: An audit was completed by the Quality Assurance Committee of all residents with current orders for psychotropic meds to determine that the rational supporting the med use, and the non-pharmacologic interventions attempted prior to the implementation of new or non-routine psychotropic meds are documented.</p> <p>Criteria 3: Inservice education was provided by the DON/ADON for the nursing staff on the documentation of resident behaviors and the use of non-pharmacologic interventions prior to the implementation of psychoactive medications on April 15th, April 16th, April 17th, April 18th and April 21st of 2014.</p>		



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

Steve Brown

TITLE

N. H. A.

(X6) DATE

4-28-2014

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 329	Continued From page 1 and review of the facility's policy and procedure it was determined that the facility failed to ensure one (1) of eighteen sampled residents (Resident #9), was free from unnecessary drugs related to the use of Trazodone (antidepressant) without adequate indication for its use. The findings include: Review of facility policy titled, "Behavioral Modification Program", (not dated), revealed once a behavior had been identified, a behavioral management plan is implemented. A four step plan provides the methods of problem solving needed to deal with behavioral symptoms in a quick and consistent way. The Four Step Plan includes the following steps, 1. Take immediate action to control a threatening or dangerous behavioral symptom, 2. Medical evaluation to look for medical or other causes of the behavior symptom that need treatment, 3. Behavior assessment to observe and describe the behavior. 4. Care plan development to decide upon realistic goals for behavior change and the steps needed to reach these goals. This includes trying the care plan and then evaluating it to see how well it worked. Further review revealed an attempt will be made to implement a behavior modification program for all residents exhibiting a behavioral problem prior to the physician ordering a psychotropic medication. Record review revealed Resident #9 was admitted to the facility on 01/02/13 with diagnoses which included Dementia without behavior, Alzheimer's Disease, Parkinson's Disease, Atrial Fibrillation, and Overactive Bladder. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 02/28/14, revealed the facility had assessed Resident #9's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of "5".	F 329	F329, continued Criteria 4: The CQI indicator for the monitoring of the use and supportive documentation for psychotropic medications will be utilized monthly X 2 months and the quarterly thereafter as per the CQI calendar, under the supervision of the DON. Findings below the required threshold of 100% will result in a plan of correction to address the identified areas. Criteria 5: April 25, 2014		

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F 329	<p>Continued From page 2</p> <p>Review of Psychiatric Visit Notes, dated 05/23/13, 09/11/13 and 12/02/13 revealed Resident #9 had no issues regarding sleep, appetite, mood or behavior.</p> <p>Review of the Comprehensive Care Plan, last updated 12/11/13, revealed the resident was care planned for Restorative level three (3) ambulation program due to at risk for decline in ambulation status related to diagnosis of altered mental status, dementia, Parkinson's and use of alarmed seatbelt to wheelchair while out of bed. The resident has limited physical mobility related to diagnosis of Parkinson's Disease. The care plan had interventions for the resident to ambulate into the dining room for meals with two (2) assist and Restorative level three (3) ambulation program daily with two (2) nursing assistants to ambulate resident with gait belt x five (5) minutes, three (3) times a day for a total of fifteen (15) minutes a day. Additionally, the care plan stated the resident is resistive to care related to diagnosis of Alzheimer's with Dementia and Impulse Disorder and a history of mood and behavior problems prior to admission. Resident #9 is Occasionally combative with care with diagnosis of Impulse Control Disorder. An intervention was implemented on 12/13/13 to "Administer Trazodone as ordered". There was no evidence the facility had attempted to implement a behavior modification program for the resident prior to ordering a psychotropic medication.</p> <p>Review of a Nurse's Note, dated 02/03/14 at 11:30 AM, revealed the Nurse Tech attempted to ambulate the resident to the dining room for lunch and the resident refused times three (3) to ambulate to the dining room.</p> <p>Review of a Psychiatric Visit Note, dated 02/04/14, revealed staff reported the resident was</p>	F 329			

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F 329	Continued From page 3 doing fine but a behavior report documented the resident was hitting and screaming at staff usually at 1 AM. Trazodone 25 milligrams (mg) at 10:00 PM was ordered at that time. Review of a Nurse's Note, dated 02/28/14, revealed the resident was up in lobby in wheel chair grabbing staff not wanting to be ambulated to the dining room. "The Nurse Tech reported he/she was kicking and grabbing at staff when transferring him to the wheelchair this AM. Resident redirected, quiet at present time". Review of a Psychiatric Visit Note, dated 03/05/14 revealed staff reported Resident #9 had several incidents of hitting and cursing at staff during ambulation to the dining room. Trazodone 25 milligrams was ordered before meals on that visit. Interview, on 04/04/14 at 2:30 PM with Licensed Practical Nurse (LPN) #1, revealed that Resident # 1 occasionally grabs tech's hand during care, however it is not often. Interview with Nurse Tech (NT) #1, on 04/04/14 at 2:35 PM, revealed she has not had any incidents of Resident #9 having behavior problems, however, occasionally Resident #9 was stubborn and would not walk to the dining room by buckling his/her knees and sitting back down in his/her wheelchair. NT #1 further stated Resident #9 had never been aggressive with her. Interview with NT #2, on 04/04/14 at 2:47 PM, revealed occasionally Resident #9 would reach out and grab staff and sometime would not let go. The NT stated the resident does not grab you to hurt you. The NT revealed Resident #9 sometimes walks to the dining room, it's just a matter of getting him/her to understand what you want him/her to do and get him/her going. NT #2 further stated she has never known the resident to hit/kick or be aggressive. Interview, on 04/04/14 at 3:00 PM with NT #3,	F 329			

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F 329	Continued From page 4 revealed she had never witnessed Resident #9 to be combative. NT #3 stated the resident just refused sometimes and when he/she doesn't want to walk, he/she just sits down in the wheelchair. Interview with Pharmacist, on 04/04/14 at 1:52 PM, revealed Trazodone was not an ideal medication for elderly residents and it would have been a better choice to try something else before trying Trazodone. Interview with the Physician, on 04/04/14 at 3:15 PM, revealed Trazodone was ordered for the resident due to the resident having trouble sleeping at night and he was not aware of any behaviors. The Physician stated any behaviors would be addressed through Psych Services. An attempt at interviewing the physician at Psych Services was unsuccessful. A message was left with answering service and not returned. Interview with the Director of Nursing, on 04/04/14 at 4:15 PM, revealed the care plan was not updated to address increased behaviors of the resident resisting going to the dining room before the Trazodone was added and should have been. When asked if the facility followed the Behavior Modification Program, Four Step Plan, he/she was unable to answer.	F 329			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1978, and upgraded in 2007 with smoke detectors and heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1978 and upgraded in 1999.</p> <p>GENERATOR: Type II generator installed in 1999. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code Survey was conducted on 04/02/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-four (94) beds with a census of eighty-seven (87) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000			
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of eight (8) smoke compartments, sixty-eight (68) residents, staff and visitors. The facility has the capacity for ninety-four (94) beds and at the time of the survey, the census was eighty-seven (87). The findings include: Observation, on 04/02/14 at 11:54 AM with the	K 025	K 025 NFPA 101 Life Safety Code Standard Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Criteria 1: The smoke partition extending above the ceiling located on the green and brown halls have been repaired with drywall to resist the passage of smoke, as done by the contracted company. Criteria 2: An inspection was completed by the Director of Maintenance of all of the smoke partitions in the attic to determine that they were all properly constructed to resist the passage of smoke. No other areas were identified requiring repairs. Criteria 3: The maintenance staff have received inservice education by the Administrator on the maintenance of smoke partitions to resist the passage of smoke in accordance with the K025, as provided on April 7, 2014.		

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K 025	<p>Continued From page 2</p> <p>Administrator, revealed the smoke partition, extending above the ceiling located on the green hall was not equipped with drywall on one (1) side of the studs in the attic.</p> <p>Interview, on 04/02/14 at 11:56 AM with the Administrator, revealed he was unaware the wall was not properly constructed to resist the passage of smoke.</p> <p>Observation, on 04/02/14 at 12:10 PM with the Administrator, revealed the smoke partition, extending above the ceiling located on the brown hall was not equipped with drywall on one side of the studs in the attic.</p> <p>Interview, on 04/02/14 at 12:12 PM with the Administrator, revealed he was unaware the wall was not properly constructed to resist the passage of smoke.</p> <p>The census of eighty-seven (87) was verified by the Administrator on 04/02/14. The findings were acknowledged by the Administrator and verified by the Administrator at the exit interview on 04/02/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed 	K 025	<p>K025, continued</p> <p>Criteria 4: The CQI indicator for the monitoring of smoke partitions in accordance with Life Safety Code requirements will be utilized monthly X 2 months and then quarterly thereafter, under the supervision of the Director of Maintenance.</p> <p>Criteria 5: May 16, 2014</p>		

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K 025	Continued From page 3 for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K 144 NFPA 101 Life Safety Code Standard Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. Criteria 1: The transfer time for the generator was added to the required documentation on the weekly generator test information form. Criteria 2: The transfer time for the generators has been documented with the weekly tests on the generator test information form by the maintenance staff. Criteria 3: The maintenance staff have received inservice information from the Administrator on the need to document the transfer time for the generator as part of the weekly generator test information form, as provided on April 07, 2014. Criteria 4: The CQI indicator for the monitoring of documentation of the generator transfer time will be utilized monthly X 2 months and then quarterly thereafter, under the supervision of the Director of Maintenance. Criteria 5: May 16, 2014		

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K 144	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect eight (8) of eight (8) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety-four (94) beds and at the time of the survey, the census was eighty-seven (87). The findings include: Generator run log review, on 04/02/14 at 11:30 AM with the Administrator, revealed the transfer time for the generator was not being documented at the facility. Interview, on 04/02/14 at 11:31 AM with the Administrator, revealed he was unaware of the requirement to document the transfer time on his monthly load test paperwork. Further interview revealed he knows it transfers very rapidly but was unaware of the exact seconds. The census of eighty-seven (87) was verified by the Administrator on 04/02/14. The findings were acknowledged by the Administrator and verified by the Administrator at the exit interview on 04/02/14. Actual NFPA Standard:	K 144			

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K 144	Continued From page 5 Reference: NFPA 101 (2000 ed.) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.	K 144		
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