STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185196	A. BUILDING _____ B. WING _____	06/17/2015

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 Amended 07/21/15 An Onsite Revisit for the 04/08/15 Abbreviated Survey, in conjunction with the Recertification Survey was initiated on 06/14/15. The survey was concluded on 06/17/15 with deficiencies as a result of the Recertification Survey cited at the highest scope and severity of an "E". The Onsite Revisit determined 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225 and F226), and 42 CFR 482.20 Resident Assessment (F279) cited during the 04/08/15 survey were corrected on 04/21/15 as alleged. After supervisory review it was determined 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F314) rose to the level of actual harm with a scope and severity of a "G".	F 000		
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to convey upon death, the personal funds deposited with the facility to the individual or	F 160	F160B Immediate Action Taken: The Resident Trust Fund for Resident A was appropriately conveyed to the estate of Resident A on 5/29/15 by the Business Office Manager. Potential to Affect Others: The estate of the deceased individual has the potential to be affected.	6/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X _____ TITLE: X Executive Director X (X6) DATE: 7/27/15

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 160	Continued From page 1 probate jurisdiction administering the resident's estate as provided by State Law within thirty (30) days for one (1) resident account out of five (5) reviewed resident accounts, Unsampled Resident A. The resident's trust fund balance deposited with the facility for Unsampled Resident A was applied to the resident's funeral bill and not conveyed to the legal representative. Further, the funds were applied after the thirty (30) day period provided by State Law. The findings include: Review of the facility's policy regarding Resident Trust Statements/Discharges and Medicaid Eligibility, dated 04/30/15, revealed the facility was to have disbursed the resident funds within thirty (30) days of the resident's death. The facility was required to refund the resident funds to the individual, stated agency, or probate jurisdiction administering the estate. Review of the facility's records pertaining to the conveyance of personal funds for expired residents revealed the facility released the personal funds for Unsampled Resident A forty (40) days after the resident expired. Unsampled Resident A expired on 04/19/15. The facility released personal funds for $753.09 to a funeral home on 05/29/15. Review of a copy of the check administered from the resident's personal trust fund, dated 06/02/15, revealed the facility paid $753.09 to the funeral home and cemetery that handled the resident's burial. Interview with the Business Office Manager, on 06/17/15 at 3:50 PM, revealed the facility	F 160	Action Taken to Prevent Recurrence: A Resident Trust Fund Audit was performed on 6/17/15 by the Manager of Field Accounting to determine if any other Resident Trust fund accounts needed refunds. Any Resident Trust fund identified at that time needing a refund was conveyed to the proper legal representative and/or the estate of as appropriate. The Business Office Manager was educated by the Executive Director on the facility procedure on conveyance of Resident Trust funds after discharge on 6/17/15. A monthly review will be performed by the Business Office Manager of all Resident Trust funds needing refunds. Any Resident Trust fund needing a refund will be conveyed to the proper legal representative and/or estate as appropriate. Monitoring:	

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F 160	Continued From page 2 released the personal funds for Unsampled Resident A more than thirty (30) days after the death of the resident. The Business Office Manager stated the resident had no estate and the facility was required to send the resident funds to the probate jurisdiction. She further stated the resident's prior Power Of Attorney (POA) had requested the facility make the payment directly to the funeral home who served the expired resident. The Business Office Manager stated the facility had some delay in obtaining a bill from the funeral home, and this resulted in the facility sending the funds to the funeral home in forty (40) days rather than within thirty (30) days. Interview with the Field Accounting Manager, on 06/17/15 at 3:55 PM, revealed the facility did not send the resident funds to probate when a resident did not have an estate because probate did not accept resident fund checks. She stated the probate would let the check expire, and then the facility would send the money to the expired resident's next of kin. Interview with the Executive Director, on 06/17/15 at 4:00 PM, revealed Unsampled Resident A's POA requested the facility pay the funeral home with the resident's remaining funds.	F 160	The monthly Resident Trust Fund Audit by the Business Office Manager will be reviewed by the Executive Director to ensure timely proper conveyance of Resident Trust funds for the next three months or until substantial compliance is received. Compliance will be maintained by continued meetings with Business Office Manager and Executive Director monthly regarding overall financial review of the facility.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F280E Corrective Action Taken: Resident #2 no longer resides at the facility. Therapy services evaluated and set up a treatment plan for Resident # 2 on 6/17/15 based on	

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F 280	Continued From page 3 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to revise care plans for five (5) of twenty-two (22) sampled residents (Residents #2, #4, #7, #8, and #15). The facility failed to revise Resident #2's care plan to include new therapy orders. In addition, the facility failed to revise care plans for Residents #4, #7, #8, and #15 to include interventions to anchor the indwelling catheters. The findings include: Review of the facility's policy regarding Indwelling Catheters, dated 08/31/12, revealed catheter tubing was secured using an anchoring device to prevent movement and urethral traction. 1. Review of the clinical record for Resident #2 revealed the facility admitted the resident with	F 280	the physicians' order. The care plan was updated by DNS to evaluate as indicated by the Wound Nurse Practitioner The indwelling catheters for Residents #8, #7, #4 and #15 were immediately anchored on 6/17/15, by LPN and Unit Manager. Each Residents' (# 8, #7, #4 and #15) Plan of Care was revised on 6/17/15 by Director of Nursing (DNS). Potential to Affect Others: All residents have the potential to be affected. Action Taken to Prevent Reoccurrence: - The Unit Directors, Director of Nursing, MDS nurse, Case Manager Nurse, Therapy Program Director completed an audit of 103 (Total census) residents' plan of care, C.N.A. assignment sheets, physicians orders (including therapy orders), and a visual inspection of the residents and the residents'	

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F 280	Continued From page 4 diagnoses of Type II Diabetes, Stage IV Pressure Ulcer on the buttock, Acute Osteomyelitis, Depression, Paraplegia, Protein-Calorie Malnutrition, Muscle Weakness and Acute Osteomyelitis. Review of Resident #2's Annual MDS assessment, completed by the facility on 05/15/15, revealed the facility assessed the resident as requiring total assistance from staff for bed mobility, dressing, and toileting care. Resident #2 also required extensive assistance to complete personal hygiene and required a two (2) person staff assist to transfer with the use of a Hoyer lift. A Brief Interview for Mental Status (BIMS) exam was conducted during the assessment and the resident scored a fourteen (14) out of fifteen (15) meaning the resident was interviewable. Review of the Care Plan, dated 08/12/14, for Resident #2, reviewed on 06/15/15 with a target date of 09/07/15 revealed no evidence the care plan was reviewed and revised to reflect new orders for physical therapy. Review of the Physician's Orders, dated 06/10/15, revealed an order was written for Resident #2 to receive Physical Therapy. Physical Therapy was to assist the resident up into a wheelchair with a Roho cushion up to one hour at a time, two times per day. Review of the Nurses' Notes for Resident #2, dated 06/10/15 at 3:45 PM, revealed the nurse transcribed the physician's order for physical therapy and noted the new orders in the nursing notes. There was no evidence the facility sent a Physical Therapy referral form to the therapy	F 280	rooms. Any inconsistencies identified on the audit were corrected immediately by Unit Directors and Director of Nursing. The Nurse Aide Assignment Sheets were updated to include indwelling catheter tubing placement and/or anchoring. This was completed by the Unit Directors by 7/14/15. The Licensed Nurses were educated on the care planning process and the importance of having current and up-to-date Plans of Care. This was completed on 7/14/15, by the Staff Development Coordinator. The facility implemented the Referral to Rehab Services Form. This form will be completed by the Licensed Nurse who obtains a physician's order for therapy services. The nursing and therapy staff was educated on the Referral to Rehab Services Form on 7/14/15 by the Staff Development Coordinator	

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F 280	Continued From page 5 department. Interview with Resident #2, on 06/15/15 at 1:30 PM, revealed he/she was on bed rest and wanted to get out of the bed. Resident #2 stated he/she was unaware the physician had placed an order on 06/10/15 for Physical Therapy to assist the resident to get into a wheelchair twice per day for an hour at a time. The resident stated he/she had not received Physical Therapy since the order was written. Interview with CNA #4, on 06/16/15 at 5:10 PM, revealed the CNA provided care for Resident #2. CNA #2 stated Physical Therapy used to assist Resident #2 to get into a wheelchair, then his/her wounds became worse and the resident's physician placed him/her on bed rest. Interview with the MDS Coordinator, on 06/17/15 at 2:42 PM, revealed she did not update the care plan for Resident #2 after the physician ordered Physical Therapy on 06/10/15. She stated she should have updated the care plan for Resident #2 when the Interdisciplinary Team read those orders at morning meeting. 2. Review of Resident #8's clinical record revealed the facility re-admitted the resident on 12/11/14, with the diagnoses of a Left Above the Knee Amputation, Acute Transverse Myelitis, Paraplegia, Peripheral Vascular Disease (PVD), and Neurogenic Bladder. Review of Resident #8's Quarterly MDS assessment, completed on 05/07/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as fifteen (15) of fifteen (15) and interviewable.	F 280	With all education provided the SDC did implement a post test for the staff to complete to validate understanding. This was completed by 7/14/15 after all education sessions. The Unit Directors will audit proper anchoring of catheter tubing placement three times a week during walking rounds. They will visibly inspect all residents with indwelling catheters to assess the tube placement and anchoring. If tube placement or anchoring is not properly in place and secured, the Unit Director will immediately correct and educate responsible nursing staff as indicated. The findings of audits will be provided to the DNS by the Unit Directors and then further tracked and trended through the Performance Committee monthly or as needed. Monitoring:	

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F 280	Continued From page 6 Review of the Comprehensive Care Plan for Resident #8, dated 06/25/13, with goal revision on 02/18/15 and the target date of 08/27/15. Problems on the care plan included the resident was at risk for skin breakdown related to decreased mobility, edema (swelling), and an indwelling catheter. The care plan included the resident was at risk for complications associated with PVD, imitated on 06/25/13, and goal target date was 08/27/15. Interventions listed on the care plan included: ensuring the catheter tubing was positioned properly, and, monitor for signs and symptoms of injury, infection or ulcers. Observation, on 06/17/15 at 2:45 PM, revealed during the dressing change and skin assessment with the Advanced Registered Nurse Practitioner (ARNP), when Resident #8 requested the ARNP to look at his/her left posterior thigh. The indwelling catheter tubing was not anchored. Interview with Licensed Practical Nurse (LPN) #7, on 06/17/15 at 3:00 PM, revealed he was not aware if positioning of the catheter tubing was on the care plan. The tubing was supposed to be anchored and not laid on by the resident. Anchoring the tubing keeps the resident from laying on the tubing. Interview with Resident #8, on 06/17/15 at 3:05 PM, stated the indwelling catheter tubing was anchored at times and other times was not anchored. 3. Review of Resident #4's clinical record revealed the facility admitted the resident on 06/10/13, with diagnoses of Quadriplegia, Osteoporosis, Insomnia, Generalized pain,	F 280	The Plans of Care for residents with indwelling catheters will be audited by the Interdisciplinary Team (IDT) to include but not limited to the Unit Directors, MDS Coordinator, Social Service Director, Activities Director, and Registered Dietician on a quarterly basis to ensure accuracy and proper revision. The Unit Directors will perform three audits per week by conducting walking rounds and visually inspecting placement of catheter tubing, anchoring, and positioning of catheter tubing x3 months, to ensure compliance with proper anchoring. All findings from the walking rounds by the Unit Directors that include proper anchoring, positioning and placement of indwelling catheters and the quarterly plans of care audits will be reviewed by the Director of Nursing and will be tracked and trended through the Performance Improvement Committee to include but not limited to the Medical Director,	

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F 280	Continued From page 7 Edema, Unspecified Spinal Cord Injury, and Spasm of Muscle. Review of Resident #4's quarterly MDS assessment, completed on 05/02/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as an eleven (11) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan, dated 03/31/15, for Resident #4 revealed goal revisions on 05/20/15 and the target date of 08/27/15, for an indwelling catheter. Interventions listed included: ensuring the catheter tubing was positioned properly; observe urine for changes in characteristics, foul odor, and pain; and, provide catheter care every shift. Observation, on 06/17/15 at 3:40 PM, with Certified Nursing Assistant (CNA) #3 present, revealed Resident #4's indwelling catheter bedside drainage bag was placed in a dignity bag on the resident's left side of the bed. The indwelling catheter tubing was not anchored to the resident's leg. The catheter tubing was laying on top of the resident's thigh area, no skin breakdown was noted. Interview with CNA #3, on 06/17/15 at 3:40 PM, revealed indwelling catheter tubing was supposed to be anchored to the resident's leg to prevent the catheter tubing from moving. Interview with Resident #4, on 06/17/15 at 3:40 PM, revealed the indwelling catheter tubing had been anchored to his/her leg with tape at times. 4. Review of Resident #15's clinical record revealed the facility admitted the resident on	F 280	Executive Director, Director of Nursing, Unit Directors, Social Service Director, Activities Director and the Registered Dietician monthly or until substantial compliance is achieved. Compliance will be maintained by continued Unit Directors performing walking rounds on their units.	

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F 280	Continued From page 8 10/08/14, with diagnoses of Idiopathic Peripheral Neuropathy, Benign Prostatic Hypertrophy with Urinary Obstruction, Muscle Disorder, Pressure Ulcers, Obesity and Diabetes. Review of Resident #15's Quarterly MDS assessment, completed on 04/02/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as fifteen (15) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan, dated 10/28/14, for Resident #15 revealed a target date of 07/23/15, for an indwelling catheter. Interventions listed included: ensuring the catheter tubing was positioned properly; observe for urinary tract infection; monitor intake and output; and, monitor for pain and discomfort. Observation, on 06/17/15 at 3:45 PM, with Registered Nurse (RN) #1 present, revealed Resident #15's indwelling catheter bedside drainage bag was placed in a dignity bag on the resident's left side of the bed. The indwelling catheter tubing was not anchored to the resident's leg. The catheter tubing was laying on top of the resident's left thigh, no skin breakdown was noted. Interview with RN #1, on 06/17/15 at 3:45 PM, revealed the indwelling catheter tubing was usually anchored to the resident's leg to keep the catheter tubing in place and to keep the resident from laying on the tubing. Interview with Resident #15, on 06/17/15 at 3:45 PM, revealed the indwelling catheter tubing was usually anchored to his/her leg with tape.	F 280		

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F 280	Continued From page 9	F 280		

5. Review of Resident #7's clinical record revealed the facility admitted the resident on 08/22/14, with diagnoses of Dementia, Pressure Ulcer of Buttock, Hypertension, Atrial Fibrillation and Anemia.

Review of Resident #7's Quarterly Minimum Data Set (MDS) assessment, completed on 05/11/15, revealed the facility assessed the resident during a Brief Interview of Mental Status (BIMS) as two (2) of fifteen (15), which meant the resident was not interviewable.

Review of the Comprehensive Care Plan for Resident #7 revealed the facility developed a care plan on 08/26/14. Problems on the care plan included the resident was at risk for falls related to increased fall risk score, poor cognition, poor safety awareness and past attempts to get out of bed unassisted. In addition, the care plan included the resident was at risk for skin breakdown related to current pressure area, decreased mobility and history of decreased nutritional intake. The care plan also stated that Resident #7 care plan meet his/her own daily care needs without assistance from staff. The care plan had an intervention related to daily care needs of an indwelling catheter to bedside drainage. There was no indication that the catheter should be anchored to his/her leg.

Observation, on 06/16/15 at 3:20 PM, revealed Resident #7 was laying in the bed with a drainage bag placed on the resident's left side of the bed.

Interview with the Director of Nursing, on 06/17/15 at 4:00 PM, revealed the facility policy included the indwelling catheter tubing should be anchored to maintain positioning, to keep the

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F 280	Continued From page 10 tubing from being under the resident. She stated the intervention to anchor the indwelling catheter was not included on Resident's #4, #7, #8 and #15 care plans; however, it was the policy, as well, and should have been included on the care plans. Continued interview with the MDS Coordinator, on 06/17/15 at 2:42 PM, revealed she would review and update care plans as appropriate per the information from the physician's orders. The MDS Coordinator further stated she received a copy of the physician orders daily; however, she revealed she did not go through the physician's orders on a daily basis to ensure the care plan was reviewed and revised.	F 280		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy,a post fall investigation, the Lippincott Manual of Nursing Practice, and Mosby's Long Term Care Assistants, it was determined the facility failed to follow the comprehensive care plan for two (2) of twenty-two (22) sampled residents (Residents #6 and #8). The facility failed to ensure the indwelling catheter was anchored for stabilization to prevent complications of skin breakdown for Resident #8. The facility failed to ensure	F 282	F282D Immediate Action Taken: The indwelling catheter tubing for Resident #8 was immediately repositioned and anchored by the Licensed Practical Nurse. The affected area was immediately assessed by the Nurse Practitioner and a head-to-toe skin evaluation was completed by the LPN. A Pain Assessment was completed at that time. A treatment order was written by the Nurse Practitioner and immediately initiated on 6/17/15	7/15/15

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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 282	Continued From page 11 contracture devices were applied to Resident #6's hands. The findings include: Review of the facility's policy for, Comprehensive Plan of Care, dated 08/31/12, revealed the care plan identified resident-centered interventions to address the means for how the resident would meet their goals. However, it did not address potential complications from the use of an indwelling catheter and lack of anchoring the tubing to prevent the resident from developing pressure areas. Review of the facility's policy regarding Indwelling Catheters, dated 08/31/12, revealed care and treatment would be provided to reduce catheter associated complications. The policy further stated under Conditions which may occur related to complications from catheter use listed Urinary Tract Infection; Bacteremia; Febrile episodes; Bladder stones; Fistula formation; Erosion of the urethra; Epididymitis; Chronic renal inflammation; Pyelonephritis; and, Blocked catheters. However, the policy did not specify potential complications from lack of anchoring the tubing to prevent the resident from laying on the tubing and developing pressure areas. Review of the Lippincott Manual of Nursing Practice, 10th Edition, 2014, Section Pressure Ulcers, page 183, revealed pressure applied for longer than 2 hours could produce tissue destruction; healing cannot occur without relieving the pressure. Section Catheterization, page 781, revealed properly anchoring the catheter prevented catheter movement and traction on the urethra; keeping the tubing over the patient's leg	F 282	The Plan of Care for Resident #8 was updated and revised by the Director of Nursing to reflect the presence of skin breakdown and appropriate interventions. This was completed on 6/17/15. The Licensed Nurse was performing a Weekly Skin Assessment on Resident #6 at the time of the surveyor observation on 6/16/15. The physician and/or Advanced Registered Nurse Practitioner (ARNP) were notified of the presence of a reddened/purple colored area and an order was obtained to place all devices on "hold" to the right upper extremity. The Restorative Nurse responsible for communicating the change from the Restorative Program to nursing for Resident #6 was re-educated on the proper process. This was completed by the DNS on 6/18/15.	

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F 282	Continued From page 12 helped prevent kinking or forming loops of stagnant urine; and, maintaining unobstructed urine flow to prevent reflux of contaminated urine into the bladder or pooling of urine in the loops of the tubing. Review of the Mosby, 4th Edition, Long Term Care Assistants, 2003, page 363, Section Care for Persons with Indwelling Catheters, revealed urine should be allowed to flow freely through the catheter tubing, should not have kinks and the person should not lie on the tubing. The catheter should be anchored to the inner thigh to prevent excessive catheter movement and friction. 1. Review of Resident #8's clinical record revealed the facility re-admitted the resident on 12/11/14, with diagnoses of a Neurogenic Bladder, Peripheral Vascular Disease (PVD), Left Above the Knee Amputation, Paraplegia, and Acute Transverse Myelitis. Review of Resident #8's Quarterly MDS assessment, completed on 05/07/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as fifteen (15) of fifteen (15) and interviewable. Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a care plan on 06/25/13, with goal revisions on 02/18/15 and the target date for 08/27/15. Problems on the care plan included the resident was at risk for skin breakdown related to decreased mobility, edema (swelling), and an indwelling catheter. Interventions listed on the care plan included ensuring the catheter tubing was positioned properly. However, the care plan did not address potential complications related to not anchoring	F 282	The Plan of Care for Resident #6 was revised to reflect the current physician orders of the upper extremity devices being on hold. This was completed by the DNS on 6/17/15. Potential to Affect Others: All residents have the potential to be effected. The Unit Director, Director of Nursing, MDS nurse, Case Manager Nurse, Therapy Program Director completed an audit of 103 (Total census) residents' plan of care, C.N.A assignment sheets, physicians orders (including therapy orders),and a visual inspection of residents and residents' rooms. Any inconsistencies identified by the audit were corrected immediately by Unit Directors and Director of Nursing. Action Taken to Prevent Recurrence: All residents with indwelling catheters were assessed by the Director of Nursing on 6/17/15 for any areas of skin breakdown related	

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F 282	Continued From page 13 the tubing. In addition, the care plan included the resident was at risk for complications associated with PVD, imitated on 06/25/13, and goal target date was 08/27/15. Intervention included monitor for signs and symptoms of injury, infection or ulcers. Observation, on 06/14/15 at 3:20 PM and, on 06/16/15 at 2:20 PM, revealed Resident #8's indwelling catheter bedside drainage bag was in a dignity bag placed on the resident's left side of the bed. Observation, on 06/17/15 at 10:40 AM, revealed Resident #8's indwelling catheter bedside drainage bag was in a dignity bag placed on the resident's left side of the bed. Observation, on 06/17/15 at 2:45 PM, during the dressing change and skin assessment with the Advanced Registered Nurse Practitioner (ARNP) revealed Resident #8 had a new area of skin pressure measuring 9.5 cm X 2.5 cm X 0.1 cm. deep, the skin was pink and shiny with the top layer of the blister missing on his/her left posterior thigh. The bedside drainage bag was hanging on the left side of the resident's left side of the bed and the indwelling catheter tubing was not anchored. Interview with the ARNP, on 06/17/15 at 2:45 PM, revealed the area was the size and shape of the catheter tubing and connector where it laid under the thigh and caused a blister and skin breakdown. The ARNP stated the resident's indwelling catheter tubing should be anchored to prevent trauma, thus ensuring the resident did not lay on the tubing, failure to do so caused the blister to occur.	F 282	to improper positioning of the catheter tubing, with no findings noted. The Nursing Staff was re-educated by the Staff Development Coordinator beginning on 6/17/15 on proper positioning and placement of indwelling catheter tubing and following the Plan of Care. This was completed by 7/14/15. With all education provided the SDC did implement a post test for the staff to complete to validate understanding. This was completed by 7/14/15 after all education sessions. SDC will perform competencies with any staff needing further understanding. No further educational competency was noted at this time with this education session. Newly hired nursing staff will be educated by the Staff Development Coordinator during orientation regarding the need for proper positioning, placement and	

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F 282	Continued From page 14 Interview with Resident #8, on 06/17/15 at 3:05 PM, revealed the indwelling catheter tubing was anchored at times and other times was not anchored. Interview with Licensed Practical Nurse (LPN) #7, on 06/17/15 at 3:00 PM and LPN #6 on 06/17/15 at 3:15 PM, revealed Resident #8's catheter tubing should not be under the resident's extremities. The tubing was supposed to be anchored to keep the tubing out from under the resident. Per LPN #7, anchoring the tubing prevented the resident from laying on the tubing. Interview with Certified Nurse Aide (CNA) #2, on 06/17/15 at 3:30 PM, revealed indwelling catheter tubing was supposed to be secured with an anchor type system so the tubing did not get under the resident's legs. She stated the catheter tubing could cause blisters and skin sores. Interview with the Director of Nursing, on 06/17/15 at 4:00 PM, revealed the facility policy included the indwelling catheter tubing should be anchored to maintain positioning to keep the tubing from under the resident, per the resident's plan of care. 2. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 09/02/14 with diagnoses of Diabetes Type II, Essential Hypertension, Morbid Obesity, Seizures, Chronic Respiratory Failure, Cerebral Vascular Disease, a history of Gangrene, Pressure Ulcers, and Contractures of his/her hands. Review of Resident #6's Minimum Data Set	F 282	anchoring of indwelling catheter tubing as per the Plan of Care. The nurse responsible for the miscommunication was re-educated on 6/17/15 by the Director of Nursing regarding the proper procedure of discharging residents from Restorative programs to nursing staff. Said nurse has been removed from the restorative position on 7/1/15. Written education/instructions will be completed by the Restorative Nurse or Unit Director to the nursing staff on specific resident instructions prior to discharge from a restorative program. The education/instructions will be placed into the C.N.A. books for further review if needed. The current Physician's Orders for devices and programs were reviewed and updated by the Director of Nursing, Case Manager and Therapy Program Director by 7/14/15.	

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F 282	Continued From page 15 (MDS) quarterly assessment, dated 03/26/15, revealed the resident had been diagnosed with hand joint contractures, and was assessed to have limited upper extremity range of motion on one side of his/her body. In addition, the resident needed extensive assistance with dressing, toilet use, personal hygiene and bathing. Review of Resident #6's clinical record (care plan), revealed one of the goals was to be free from complications of Cerebral Vascular Accident (CVA) including Contractures, Deep Vein Thrombosis, Aspiration Pneumonia, and Dehydration, with a target date of 07/23/15. Restorative Nursing Services was listed as an intervention toward achieving that goal. Review of Resident #6's care plan for Daily Care Needs, related to his/her history of a CVA, revealed the care plan was initiated on 10/14/14 and listed restorative nursing services. In addition, staff were to monitor for any declines and/or contractures and to refer the resident back to therapy, as needed. Further review of Resident #6's clinical record, revealed the CNA Nursing Order Flow Sheet Record/Restorative Care Plan for June 2015 listed application of a bilateral Upper Extremity (UE) left-hand palm guard, a right UE soft elbow extension splint and carrot othsosis, every day, 5-6 times per week, but there were no staff initials on this document to verify the devices had been applied. Review of the Certified Nursing Assistant (CNA) Assignment Sheet, titled Twin Spires East, dated 06/14/15, did not reveal any information about Resident #6's left-hand palm guard, his/her elbow	F 282	The Nurse Aide Assignment Sheets were updated by the Unit Directors to reflect current orders for placement of devices on 7/14/15. The Nursing Staff will be educated on the proper identification and process for placement of devices. This was completed on 7/14/15, by the Staff Development Coordinator (SDC). The Licensed Nurses were educated by the SDC and DNS with education including: on how to revise and implement a care plan. Visual hand outs were given to the licensed nurses for examples. Care Plans are being validated as being completed/revised/implemented with review in the morning meeting. All current Physician's Orders for placement of devices will be reviewed by The Director of Nursing and/or Unit Directors by 7/14/15 to insure appropriate follow through. The Nurse Aide Assignment Sheets will be updated to reflect the appropriate orders.	

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F 282	Continued From page 16 extension, or the soft carrot for placement in the resident's right hand. Further review of Resident #6's clinical record, revealed the CNA Nursing Order Flow Sheet Record for June 2015 listed application of a bilateral Upper Extremity (UE) left-hand palm guard, a right UE soft elbow extension splint and carrot othsosis, every day, 5-6 times per week, but there were no staff initials on this document to verify the devices had been applied. Observation, on 06/14/15 at 6:20 PM, revealed Resident #6 did not have his/her hand splint, elbow device, or soft carrot in place. Observation, on 06/15/15 at 10:48 AM, revealed the soft carrot device was on the resident's bedside table, not in the resident's right hand. Observation, on 06/15/15 at 3:30 PM, revealed Resident #14's hands were in a closed position, and he/she did not have a palm guard on his/her left hand nor a carrot device in his/her right hand. Observation, on 06/16/15 at 8:50 AM, revealed Resident #6's hands were exposed and the palm guard and the soft carrot had not been applied to his/her hands. The soft carrot was observed on the bedside table next to the resident's bed. Observation, 06/16/15 at 10:30 AM, of the skin assessment and wound care for Resident #6, revealed the resident did not have the soft carrot in his/her right hand or the left hand palm guard in place at the beginning or during any portion of the skin assessment and wound care provided by the resident's nurse. Interview, on 06/17/15 at 10:20 AM with Licensed	F 282	Monitoring: The Unit Directors will perform three audits per week x3 months, to ensure compliance with proper anchoring. The Director of Nursing and/or Unit Directors will audit the Nurse Aide Assignment Sheets and Nurse Aide Flow Records for accuracy and completeness on a weekly basis x 8 weeks and then monthly thereafter. If a negative finding is noted with audits, it will be immediately corrected and educated on by Unit Director and/or Director of Nursing. All findings from audits will be reviewed and tracked and trended by the DNS and reviewed monthly by the Performance Improvement Committee times 3 and/or until substantial compliance is achieved. Compliance will be maintained by continued Unit Directors performing walking rounds on their units. SDC will continue to have staff to perform annual competencies as per facility policy.	

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F 282	Continued From page 17	F 282		

Practical Nurse (LPN) #1, revealed she thought restorative CNAs were to perform restorative care for Resident #6, but stated she was not sure when restorative care was provided for the resident. LPN #1 stated she thought Resident #6 sometimes tossed the carrot away after it was placed as she had seen the carrot in the resident's hand but had also found it in the resident's bed while providing care.

Interview, on 06/17/15 at 2:20 PM, with the Restorative CNA (RCNA) #1, revealed she provided restorative nursing care to Resident #6 about three (3) weeks ago, but was not currently assigned to provide restorative nursing care for the resident. The RCNA stated Resident #6 tolerated the devices with no difficulty during the time she was assigned to place the palm guard and carrot. The RCNA stated the resident had previously kept the carrot in his/her hand about three (3) hours at a time.

Interview, on 06/17/15 at 2:30 PM with CNA #2, revealed she had been assigned to care for Resident #6, but had not been told to place the carrot or the palm guard, and had never applied any splint/palm guard devices to Resident #6's hands or arms.

Interview, on 06/17/15 at 4:00 PM with the Director of Nursing (DON), revealed Resident #6 did have contractures and had been assessed for placement/use of anti-contracture devices. The DON stated the resident's history of contractures and restorative nursing was mentioned in the Activity of Daily Living (ADL)/Daily Care Needs component of the resident's care plan. Resident #6's devices should have been applied.

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F 309	Continued From page 18	F 309	F309D	7/15/15
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 observation, interview, and record review, it was determined the facility failed to transcribe orders written by the physician for Physical Therapy for one (1) of twenty-two (22) sampled residents (Resident #2). As a result, Resident #2 did not receive Physical Therapy services as ordered by the physician.

The findings include:

Interview with the Director of Nursing (DON), on 06/17/15 at 3:15 PM, revealed there was no policy addressing the transcription of physician orders and nursing did not notify Physical Therapy of the new orders for Resident #2.

Review of the clinical record for Resident #2, revealed the facility admitted Resident #2 with diagnoses of Type II Diabetes, Stage IV Pressure Ulcer on the buttock, Acute Osteomyelitis, Depression, Paraplegia, Protein-Calorie Malnutrition, Muscle Weakness and Acute Osteomyelitis.

Immediate Action Taken:

Resident #2 no longer resides at the facility. Therapy services evaluated and set up a treatment plan for Resident # 2 on 6/17/15 based on the physicians' order. The Care Plan was updated by the DNS for therapy to evaluate as indicated by the wound NP.

Potential to Affect Others:

All residents have the potential to be affected. The Unit Director, Director of Nursing, MDS nurse, Case Manager Nurse, Therapy Program Director completed an audit of 103 (Total census) residents' plan of care, C.N.A. assignment sheets, physicians orders (including therapy orders),and a visual inspection of residents and residents' rooms. Any inconsistencies identified on the audit were corrected immediately by Unit Directors and Director of Nursing. These were all completed

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F 309	Continued From page 19 Review of Resident #2's Annual Minimum Data Set (MDS) assessment, completed by the facility on 05/15/15, revealed the facility assessed the resident as requiring total assistance from staff for bed mobility, dressing, and toileting care. Resident #2 also required extensive assistance to complete personal hygiene and required a two (2) person staff assist to transfer with the use of a Hoyer lift. A Brief Interview for Mental Status (BIMS) exam was conducted during the assessment on 05/15/15 and scored the resident as a fourteen (14) out of fifteen (15) meaning the resident was interviewable. Review of the Physician's Orders, dated 06/10/15, revealed an order for Resident #2 to receive Physical Therapy. The Physical Therapist was to assist the resident up into a wheelchair with a Roho cushion up to one hour at a time, two times per day. Review of the Nurses' Notes for Resident #2, dated 06/10/15 at 3:45 PM, revealed the nurse received a physician's order and noted the new order for Physical Therapy in the nursing notes; however, there was no evidence located to validate the nurse sent a therapy request to the therapy department. Review of the nurses' notes for Resident #2, dated 06/10/15 at 3:45 PM, revealed the nurse received a physician's order and noted the new order for Physical Therapy in the medical records. Interview with Resident #2, on 06/15/15 at 1:30 PM, revealed Physical Therapy assisted the resident in the past to get out of bed and into a wheelchair. However, the resident stated that he/she had gotten sick, been admitted to the	F 309	on 7/14/15. Action Taken To Prevent Reoccurrence: The facility implemented the Referral to Rehab Services Form on 7/8/15. This form will be completed by the Licensed Nurse who obtains a physician's order for therapy services. The nursing and therapy staff will be educated on the Referral to Rehab Services Form by 7/14/15 by the Staff Development Coordinator. All new staff will be educated on the form by Staff Development Coordinator. With all education provided the SDC did implement a post test for the staff to complete to validate understanding. This was completed by 7/14/15 after all education sessions.	

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F 309	Continued From page 20 hospital, and his/her pressure wound had gotten worse. Then the physician had placed Resident #2 on complete bed rest. Resident #2 stated the complete bed rest had made his/her muscles weak and felt he/she could no longer sit up or hold up his/her head. Resident #2 stated he/she felt stuck in the bed in the room all of the time. Resident #2 stated he/she would like to get out of the bed and felt his/her quality of life would improve by getting out of the bed. Resident #2 stated he/she was unaware the physician had placed an order on 06/10/15 for Physical Therapy to assist the resident to get into a wheelchair twice per day for an hour at a time. The resident stated this had not happened. Interview with CNA #4, on 06/16/15 at 5:10 PM, revealed the CNA provided care for Resident #2. She stated Physical Therapy used to assist Resident #2 to get into a wheelchair; however, the resident's wounds became worse and the resident's physician placed him/her on bed rest. Interview with Licensed Practical Nurse (LPN) #4, on 06/17/15 at 9:05 AM, revealed the process by which nursing documented and communicated physician's orders with others in the facility was the nurse would transcribe the orders and make a note in the nursing notes. She revealed a nurse would take an order off when it was written by a physician. The nurse would then place a copy of the order into a binder for review by members of the Interdisciplinary Team to discuss in morning meeting. She stated she did not recall an order coming in for Physical Therapy for Resident #2 on 06/10/15. She stated the facility admitted Resident #2 with a large sacral pressure wound. She stated the wound was nearly healed when the resident became ill and went to the hospital	F 309	All new Physician's Orders will be reviewed the following business day in the Morning Meeting to ensure proper follow through. The orders will be copied and brought to the morning meeting by Medical Records Director. All managers that will receive the copies of orders include but not limited to: Unit Directors, MDS Coordinator, Case Manager, DNS, SDC, Medical records Director, and Rehab Director. Monitoring: The Medical Records Director and/or Director of Nursing and the Rehab Program Director will conduct weekly audits to compare physician orders to referral to rehab services forms to ensure proper follow through x 3 months. This audit will be tracked and trended by Director of Nursing and reviewed by the Performance Improvement Committee. Compliance will be monitored on a monthly basis x 3 or until substantial compliance is	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 21 for treatment. The resident returned to the facility and the wound was much worse. The Physician placed Resident #2 on bed rest at that time and the wound was healing and looking better. LPN #4 stated prior to hospitalization, Resident #2 had been receiving Physical Therapy to sit up in a wheelchair. At that time, Resident #2 could only sit up for a short time due to dizziness and pain. Interview with the Physical Therapist, on 06/17/15 at 9:40 AM, revealed the therapy department was unaware of the physician order to provide therapy to Resident #2. She stated Resident #2 had previously received Physical Therapy and the resident had been discharged. The Physical Therapist stated she did not receive a referral or information from the nursing staff that the physician had written a new Physical Therapy order for Resident #2. The Physical Therapist further stated the purpose of Physical Therapy was to restore functioning and maximize functioning potential. She stated Resident #2 would miss opportunities to get out of bed and work on restoring functioning. Interview with the Unit Manager of the Mint Julep Hall, on 06/17/15 at 1:40 PM, revealed the process by which the nursing staff would take off new medical orders and communicate the orders to the facility was either she or another nurse would take a physician's order and document the receipt of order in the nurses' notes. The nurse would place a copy of the order in a binder. Medical Records retrieved the binders, copied the information, and disseminated the information to the members of the Interdisciplinary Team. The Interdisciplinary Team met each morning in morning meeting to discuss the new orders, update care plans, and communicate new	F 309	achieved. Compliance will be maintain by all IDT members receiving copies of the orders for their review. In the event the Medical Records personal is not available for providing orders to the IDT members, the Unit Directors will present their orders to the IDT and the DNS will continually oversee this process.	

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	185196	A. BUILDING _____ B. WING _____	06/17/2015

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KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

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F 309	Continued From page 22	F 309		

information about residents. The Unit Manager reviewed the process on 06/10/15 and revealed the nurse who took the order for Resident #2's Physical Therapy documented the information in the nurses' notes per the new protocol.

Interview with Medical Records, on 06/17/15 at 2:06 PM, revealed Medical Records had retrieved and distributed the orders from 06/10/15, including the orders for Resident #2.

Interview with the MDS Coordinator, on 06/17/15 at 2:42 PM, revealed the process for communicating physician's orders to the members of the Interdisciplinary Team and the rest of the facility in the facility morning meeting. The MDS Coordinator stated a member of the Interdisciplinary Team, usually the Director of Nursing (DON), social worker, or another member would read the orders and information from the 24-hour report. She would review and update care plans as appropriate per the information from physician's orders and the 24-hour report. She stated she did not update the care plan for Resident #2 after the physician ordered Physical Therapy on 06/10/15. She stated she would have updated the care plan for Resident #2 when the Interdisciplinary Team read those orders because Resident #2 was not receiving Physical Therapy at that time. She further stated she received a copy of the physician orders daily and would go through the physician orders during quarterly and annual assessments to ensure the documentation was correct. However, the MDS Coordinator stated she did not go through the physician's orders on a daily basis to ensure the Interdisciplinary Team addressed all of the orders in morning meetings.

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F 309	Continued From page 23 Interview with the DON, on 06/17/15 at 3:15 PM, revealed the process of communicating orders and new treatments failed for Resident #2. The DON stated several issues contributed to the breakdown of the system on the morning meeting after nursing received the order on 06/10/15 for Resident #2 to receive Physical Therapy. The DON stated the Unit Manager was on vacation, the DON had to leave the interdisciplinary meeting part of the way through due to other issues, and other interruptions occurred during the meeting that day. The DON stated this was a new system and the facility continued to work the bugs out of the new system to communicate changes and updates. The DON stated the order was either not read during the morning meeting, or distractions occurred which caused everyone in the meeting to miss the order being read. The DON stated the incident put Resident #2 at increased risk for potential decline in overall health and condition.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure contracture devices were applied for one (1) of twenty-two (22) sampled residents (Resident #6).	F 311	F311 D Immediate Action Taken: The Licensed Nurse was performing a Weekly Skin Assessment on Resident #6 at the time of the surveyor observation on 6/16/15. The physician and/or Advanced Registered Nurse Practitioner (ARNP) were notified of the presence of a reddened/purple colored area and an order was obtained to place all devices on	7/15/15

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F 311	Continued From page 24 The findings include: Review of the clinical record for Resident #6, revealed the facility admitted the resident on 09/02/14 with diagnoses of Diabetes Type II, Essential Hypertension, Morbid Obesity, Seizures, Chronic Respiratory Failure, Cerebral Vascular Disease, a history of Gangrene, Pressure Ulcers, and Contractures of his/her hands. Review of Resident #6's MDS quarterly assessment, dated 03/26/15, revealed diagnoses of hand joint contractures, and was assessed to have limited upper extremity range of motion on one side of his/her body. The facility assessed Resident #6 as needing extensive assistance with dressing, toilet use, personal hygiene, and bathing. Further review of Resident #6's clinical record, revealed the CNA Nursing Order Flow Sheet Record for June 2015 listed application of a bilateral Upper Extremity (UE) left-hand palm guard, a right UE soft elbow extension splint and carrot othsosis, every day, 5-6 times per week, but there were no staff initials on this document to verify the devices had been applied. Review of Resident #6's care plan revealed he/she had a goal to be free from complications of a Cerebral Vascular Accident (CVA) including Contractures, Deep Vein Thrombosis, Aspiration Pneumonia, and Dehydration, with a target date of 07/23/15. Restorative Nursing Services was listed as an intervention toward achieving that goal. Review of the Functional Assessment, dated	F 311	"hold" to the right upper extremity. The Restorative Nurse responsible for communicating the change from the Restorative Program to nursing for Resident #6 was re-educated on the proper process for discharging a resident from the Restorative Program. The Plan of Care for Resident #6 was revised to reflect the current physician orders of the upper extremity devices being on hold. This was completed by the Director of Nursing on 6/17/15. Potential to Affect Others: All residents have the potential to be affected. The Therapy Director and Unit Directors reviewed all residents (103 total) physicians' orders for orthotic devices and/or in a Restorative program. No negative outcomes with review noted.	

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F 311	Continued From page 25 04/07/15, completed by Restorative Nursing, revealed a goal for Resident #6 to tolerate a left hand palm guard, a right upper extremity soft elbow extension splint, and a carrot to his/her right hand that was contracted. The resident's care planned goal was to tolerate application of the left- hand palm guard, soft elbow extension and carrot every day, five-six (5-6) times per week. Review of the Certified Nursing Assistant (CNA) Assignment Sheet, titled Twin Spires East, dated 06/14/15, did not reveal any information about Resident #6's left hand palm guard, his/her elbow extension, or the soft carrot for placement in the resident's right hand. Review of the CNA Nursing Order Flow Sheet Record for June 2015 listed application of a bilateral Upper Extremity (UE) left-hand palm guard, a right UE soft elbow extension splint and carrot othsosis, every day, 5-6 times per week, but there were no staff initials on this document to verify the devices had been applied. Observation, on 06/14/15 at 6:20 PM, revealed Resident #6 was in bed, awake and awaiting his/her supper meal. The resident was positioned on his/her right side, on a low air loss mattress. The resident did not have his/her hand splint, elbow device, or soft carrot in place. Observation, on 06/15/15 at 10:48 AM, revealed Resident #6 was seated in a Geri-Chair in his/her room. The soft carrot device was observed on the resident's bedside table, and not placed in the resident's right hand. Observation, on 06/15/15 at 3:30 PM, revealed	F 311	Action Taken To Prevent Reoccurrence: The nurse responsible for the miscommunication was re-educated on 6/17/15 by the Director of Nursing regarding the proper procedure of discharging residents from Restorative programs to nursing staff. Said nurse has been removed from the restorative position on 7/1/15. Written education/instructions will be completed by the Restorative Nurse or Unit Director to the nursing staff on specific resident instructions prior to discharging from a restorative program. The current Physician's Orders for devices and programs will be reviewed by the Unit Director's by 7/14/15. The Nurse Aide Assignment Sheets will be updated by 7/14/15 and as needed on an ongoing basis by the Unit Directors to reflect current orders for placement of devices.	

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F 311	Continued From page 26 Resident #6 was awake, in bed and his/her hands were visible. Resident #6's hands were in a closed position, and he/she did not have the hand splint or carrot device in either hand. During the observation, it was noted the resident had a reddened/purple colored area on the palm of his/her right hand, just below the base of the thumb, that was visible even though his/her hand was in a closed position. Observation, on 06/16/15 at 8:50 AM, revealed Resident #6 was awake, in bed and had just finished his/her breakfast. Resident #6's hands were exposed and the palm guard and the soft carrot had not been applied to his/her hands. The soft carrot was observed on the bedside table next to the resident's bed. Observation, 06/16/15 at 10:30 AM, of the skin assessment and wound care for Resident #6, revealed he/she continued to have a reddened/purple colored area on the palm of his/her right hand, just below the base of the thumb. The resident did not have the soft carrot in his/her right hand or the left hand palm guard in place at the beginning or during any portion of the skin assessment/wound care observation. Interview, on 06/16/15 at 10:40 AM, with Licensed Practical Nurse (LPN) #1, during the skin assessment revealed the site at the resident's right hand was new to him/her, and that she measured it to be 2.3 by 1.4 centimeters. LPN #1 stated she thought the area looked dark red, and it could be a blister or hematoma. LPN #1 stated she would call the Advanced Registered Nurse Practitioner (ARNP), wound care nurse, to report the area and obtain any orders for treatment.	F 311	The Nursing Staff will be educated on the proper identification and process for placement of devices as indicated by the nurse aide assignment sheet by 7/14/15 by the Staff Development coordinator, therapy, and unit directors. This education included utilizing C.N.A. assignment sheets with the emphasis on use of the adaptive equipment. Compliance will be maintained by continued Unit Directors performing walking rounds on their units. SDC will continue to have staff to perform annual competencies as per facility policy. All current Physician's Orders for placement of devices will be reviewed by The Director of Nursing and/or Unit Directors by 7/14/15 to insure appropriate follow through. The Nurse Aide Assignment Sheets will be updated to reflect the appropriate orders. Monitoring:	

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F 311	Continued From page 27 Further interview, on 06/17/15 at 10:20 AM with LPN #1 revealed she thought restorative CNAs were to perform restorative care for Resident #6, but stated she was not sure when restorative care was provided for the resident. LPN #1 stated at times Resident #6 would toss the carrot away after it was placed. She had seen the carrot in the resident's hand, but had also found it in the resident's bed while providing care. Interview, on 06/17/15 at 2:20 PM, with the Restorative CNA (RCNA) #1 revealed she provided restorative nursing care to Resident #6 about three (3) weeks ago, but was not currently assigned to provide restorative services to the resident. The RCNA stated Resident #6 tolerated the devices with no difficulty during the time she was assigned to place the palm guard and carrot. The RCNA stated the resident had previously kept the carrot in his/her hand about three (3) hours at a time. Interview, on 06/17/15 at 2:30 PM, with CNA #2 revealed she had been assigned to care for Resident #6, but had not been told to place the carrot or the palm guard, and had never applied any splint/palm guard devices to Resident #6's hands or arms. CNA #2 stated she had cleaned Resident #6's hands with a wash cloth by wrapping the cloth around her own finger to clean inside the resident's palms, but had not noticed any redness or irritation on the resident's right hand. Observation, on 06/17/15 at 1:35 PM, revealed the ARNP for the facility's wound care services visited/assessed the area on Resident #6's right hand. Interview, on 06/17/15 at 1:40 PM, with the ARNP for wound care services revealed she	F 311	The Director of Nursing and/or Unit Directors will audit the Nurse Aide Assignment Sheets and Nurse Aide Flow Records for accuracy and completeness on a weekly basis x 8 weeks and then monthly thereafter. The Restorative Nurse, Restorative Aide and Director of Nursing will meet weekly to review all residents on a restorative program and those transitioning to maintenance to insure proper communication, education and follow-through. All findings will be reported monthly by DNS and/or Restorative Nurse and tracked and trended through the Performance Improvement Committee monthly. Compliance will be monitored on a monthly basis x3 or until substantial compliance is achieved. Compliance will be maintained by restorative remaining to meet weekly to review programming and Unit Directors remaining to be responsible to ensure their unit assignment sheet reflect accuracy.	

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F 311	Continued From page 28 observed the area on Resident #6's right hand and thought the area was fluctuant and should be monitored for size and change at this time. The ARNP stated the resident should not have the carrot placed in the hand until the area reabsorbs. Interview, on 06/17/15 at 4:00 PM, with the Director of Nursing (DON) revealed she had a conversation with Resident #6's daughter and the resident's daughter thought the resident chewed on his/her right hand and this may have caused the area. The DON stated Resident #6 had a behavior of chewing his/her tracheostomy plug, picking his/her nose and playing with his/her colostomy bag, but stated she had no previous awareness that Resident #6 chewed his/her hand. The DON stated Resident #6 had contractures of both hands and anti-contracture devices that were ordered and assessed, should be in use/applied. However, the DON stated the Wound Care ARNP assessed Resident #6's hand today (06/17/15) and recommended the carrot not be placed until the area on the resident's right hand reabsorbed.	F 311	Annual competencies to be completed per facility policy by SDC with all employees.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314D Action Taken: - The indwelling catheter tubing for Resident #8 was immediately repositioned and anchored by the Licensed Practical nurse.	7/15/15

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F 314	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, review of the Lippincott Manual of Nursing Practice, and Mosby's Long Term Care Assistants, it was determined the facility failed to ensure residents at risk for pressure ulcers received the necessary treatment and services to prevent the development of new pressure ulcers for one (1) of twenty-two (22) sampled residents (Resident #8). The facility assessed Resident #8 with an avoidable pressure ulcer, on 06/17/15, related to the indwelling catheter was not stabilized by anchoring the tubing to reduce the complicatons of skin breakdown. The resident's thigh laid on the tubing and connector and developed a blistered area that sloughed the top layer of skin and progressed to a pressure area. The findings include: The facility did not provide a policy regarding pressure areas. Review of the Lippincott Manual of Nursing Practice, 10th Edition, 2014, Section Pressure Ulcers, page 183, revealed pressure applied for longer than 2 hours could produce tissue distruction; healing cannot occur without relieving the pressure. Section Catheterization, page 781, revealed properly securing the catheter prevented catheter movement and traction on the urethra; keeping the tubing over the patient's leg helps prevent kinking or forming loops of stagnent urine; and, maintaining unobstructed urine flow to prevent reflux of contaminated urine into the bladder or pooling of urine in the loops of tubing.	F 314	- The affected area was immediately assessed by the Nurse Practitioner and a head-to-toe skin evaluation was completed by the LPN. A Pain Assessment was completed at that time. - A treatment order was written by the Nurse Practitioner and immediately initiated. - The Plan of Care for Resident #8 was updated by the Director of Nursing to reflect the presence of skin breakdown and appropriate interventions. Potential to Affect Others: All residents with indwelling catheters have the potential to be effected. All residents with indwelling catheters were assessed by the Director of Nursing on 6/17/15 for any areas of skin breakdown related to improper positioning of the catheter tubing. There were no negative findings.	

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F 314	Continued From page 30 Review of the Mosby, 4th Edition, Long Term Care Assistants, 2003, page 363, Section Care for Persons with Indwelling Catheters, revealed urine should be allowed to flow freely through the catheter tubing, should not have kinks and the person should not lie on the tubing. Secure the catheter to the inner thigh to prevent excess catheter movement and friction. Review of Resident #8's clinical record revealed the facility re-admitted the resident on 12/11/14, with diagnoses of a Left Above the Knee Amputation, AcuteTransverse Myelitis, Paraplegia, Peripheral Vascular Disease (PVD), and Neurogenic Bladder. Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 05/07/15, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) as a fifteen (15) of fifteen (15) and meaning the resident was interviewable. Review of the Comprehensive Care Plan, dated 06/25/13, for Resident #8 revealed goal revisions on 02/18/15 and the target date for 08/27/15. Problems on the care plan included the resident was at risk for skin breakdown related to decreased mobility, edema (swelling), and an indwelling catheter. Interventions listed on the care plan included ensuring the catheter tubing was positioned properly. In addition, the care plan included the resident was at risk for complications associated with PVD, initiated on 06/25/13, and a goal target date of 08/27/15. Interventions included to monitor for signs and symptoms of injury, infection or ulcers. Observations of Resident #8 during the initial	F 314	Action Taken To Prevent Recurrence: All residents with indwelling catheters were assessed by the Director of Nursing on 6/17/15 for any areas of skin breakdown related to improper positioning of the catheter tubing. There were no negative findings. The Nursing Staff were re-educated by the Staff Development Coordinator beginning on 6/17/15 regarding the need for proper positioning, placement and anchoring of indwelling catheter tubing. Anchoring of indwelling catheter was also added to the C.N.A. assignment sheets. With all education provided the SDC did implement a post test for the staff to complete to validate understanding. This was completed by 7/14/15 after all education sessions. With all education provided the SDC did implement a post test for the staff to complete to validate understanding.	

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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 314	Continued From page 31 tour, on 06/14/15 at 3:20 PM, revealed a bedside drainage bag in a dignity bag for an indwelling catheter was placed on the resident's left side of the bed. Observation, on 06/16/15 at 2:20 PM, revealed Resident #8's indwelling catheter bedside drainage bag was in a dignity bag placed on the resident's left side of the bed. Observation, on 06/17/15 at 10:40 AM, revealed Resident #8's indwelling catheter bedside drainage bag was in a dignity bag placed on the resident's left side of the bed. Observation, on 06/17/15 at 2:45 PM, revealed during the dressing change and skin assessment with the Advanced Registered Nurse Practitioner (ARNP), Resident #8 requested the ARNP to assess his/her left posterior thigh. A new area was identified that measured 9.5 cm X 2.5 cm X 0.1 cm. deep, the skin was pink and shiny with the top layer of the blister missing. Observation at the time of the skin assessment revealed the resident's indwelling catheter tubing was not anchored to prevent the resident from laying ontop of it. Interview with ARNP, on 06/17/15 at 2:45 PM, revealed Resident #8 had PVD and Arterial Disease, which was the worst of both worlds. She stated the Arterial Disease lead to the swelling, plus the PVD lead to the wounds on posterior thigh. She stated the areas on Resident #8's right lower extremity was unavoidable and now healed; however, the area on his/her left posterior thigh was new. She stated the area was the size and shape of the catheter tubing and connector where he/she had it under the thigh	F 314	This was completed by 7/14/15 after all education sessions. Competencies will be completed by any staff needing further education. SDC will also have staff complete annual competencies and as indicated by ongoing monitoring. - Newly hired nursing staff will be educated during orientation regarding the need for proper positioning, placement and anchoring of indwelling catheter tubing by the Staff Development Coordinator. Monitoring: - The Unit Directors will audit placement of indwelling catheter tubing 3 times per week. Findings will be reviewed with DNS. The results of these audits will be tracked and trended by the DNS and reviewed by the Performance Improvement Committee. Overall compliance will be monitored by the Performance Improvement Committee monthly x 3 or until substantial compliance is achieved.	