

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

PRINTED: 11/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/28/2011
NAME OF PROVIDER OR SUPPLIER  HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS  An abbreviated survey investigating ARO #KY00017254 and ARO #KY00017229 was initiated on 10/23/11 and concluded on 10/31/11. ARO #KY00017254 was substantiated with deficiencies cited. ARO #KY00017229 was unsubstantiated with deficiencies cited.	F 000	<i>This Plan of Correction is the center's credible indication of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to follow their Abuse policy for one (1) of three (3) sampled residents, Resident #1, when Certified Nursing Assistant (CNA)#3 failed to report an allegation of abuse until the following day.  The findings include:  Review of the facility's policy, titled Abuse, dated 10/31/10 revealed staff are to report to the Executive Director (Administrator) or their designee and to other officials in accordance with state law.  Interview with CNA #3, on 10/25/11 at 3:00 PM, revealed on 09/24/11 she observed CNA #1 turning Resident #1 and she felt he was being rough with the resident; however, she did not	F 226	F226  1) The Staff Development Coordinator and Executive Director have counseled and in-serviced staff members involved in this event and investigation on the Abuse Policy and the correct procedures to follow.  2) The Executive Director has reviewed investigations conducted over the 60 days to assure full implementation of the facility's policies was achieved. There was no further deficient practice found  3) The Staff Development Coordinator and Executive Director have in-serviced the facility staff on the Abuse Policy with an emphasis on the prevention, intervention, and timely reporting components on 10/28/11 and 10/31/11. The Staff Development Coordinator includes information on the Abuse Policy with an emphasis on the prevention, intervention, and timely reporting components in the orientation of new personnel. The Executive Director will review each investigation, while it is being conducted to assure full implementation of the policy. Corrective action will be taken for elements found not to be fully implemented.	11/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Thomas Clark*      *Rebecca Drecht*      TITLE  
11/20/11

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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NAME OF PROVIDER OR SUPPLIER  <b>HARRODSBURG HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>883 LEXINGTON ROAD HARRODSBURG, KY 40330</b>		
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F 226	Continued From page 1 report this allegation to administration until 09/25/11. She further stated she had over heard the resident telling Licensed Practical Nurse (LPN) #1 something related to CNA #1 and thought he would report this to the Charge Nurse. Further interview revealed CNA #3 knew the facility policy related to allegations of abuse was to report them immediately; however, she thought LPN #1 would have reported the allegation. She further stated she should have reported this to the Charge Nurse immediately after she observed the situation.  Interview with LPN #1, on 10/23/11 at 03:00 PM, revealed Resident #1 had told him, he/she needed to go to the bathroom and CNA #1 would not take him/her. He further stated he spoke with CNA #3 and he stated he had taken the resident before he had put him/her to bed and the resident stated he/she had forgotten about it; therefore, he did not feel any abuse had occurred to report. Further interview revealed the resident never reported to him CNA #1 had been rough with him/her and had the resident made that statement he would have reported it to the Charge Nurse.  Interview with the Director of Nursing (DON), on 10/28/11 at 4:00 PM, revealed per policy CNA #3 should have reported the allegation to the Unit Supervisor as soon as she observed the alleged abuse.  Interview with the Administrator, on 10/28/11 at 4:30 PM, revealed per the facility policy, CNA #3 should have reported the alleged abuse to the Unit Supervisor immediately.	F 226	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  4) The Executive Director will review each abuse investigation as they occur and the Performance Improvement Committee, comprised of the Executive Director, Director of Nursing, Medical Director, Staff Development Coordinator, Registered Dietician, Maintenance Director, Social Services Director, will monitor through record review at least monthly for three months, and then quarterly, to assure all components of the Abuse Policy are fully implemented and make recommendations as needed. The Executive Director is responsible for overall compliance.	11/19/11	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	F 281  1) The nurse involved in the medication variance related to Ativan was individually counseled regarding correct procedures and a medication administration competency was completed on 10/21/11 as this was the first day she worked after the variance was made Resident # 2 received the Bisacodyl on 10/27/11. Resident # 2's physician and family were notified of the Bisacodyl medication not being administered as ordered. The Medication Administration Record was corrected to reflect the current order of Bisacodyl.		

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F 281 SS=D	Continued From page 2 <b>PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  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 provided services that meet professional standards of quality for one (1) of four (4) sampled residents, Resident #2. The facility failed to follow Phyclyan's orders for administering medications (Ativan and Biscoydal) to Resident #2 as ordered.  The findings include:  Review of the facility's polioy, titled Medication Administration, dated 08/31/11, revealed staff who prepare medications are to use the five (5) rights of medication administration, which includes right medication strength. Further review revealed staff are to clarify any orders observed to be incomplete, illegible, or presents any other concerns, prior to administering the medication.  Record review revealed the facility admitted Resident #2 on 09/19/11 with diagnoses which included Anxiety and Constipation. Review of the resident's Physician's Orders revealed an order for Ativan 0.5 mg two (2) times a day as needed for anxiety, ordered on 09/19/11 and Biscoydal 10 mg daily, ordered on 09/19/11 for constipation.  Interview with License Practical Nurse (LPN) #2,	F 281	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  2). The Director of Nursing, Executive Director and Unit Managers audited the PRN medication orders and the discontinued orders to assure there were no further variances and procedure is being followed regarding discontinued medications. There was no further deficient practice found in meeting profession standards of quality related to medication administration.  3) The Staff Development Coordinator conducted an in-service with the licensed staff on meeting professional standards with an emphasis on PRN medication administration and procedure of discontinuing a medication on 10/28/11 and 10/31/11. The Staff Development is completing Medication Administration competencies with all the Licensed Staff completed on 11/14/11. The Pharmacist Consultant will be at the facility on 11/18/11 to complete medication administration/pass audits. The Staff Development Coordinator includes information regarding meeting professional standards of quality, to include medications administration and procedure of discontinuing medications in the orientation of new licensed personnel.  4) The Staff Development Coordinator will	11/19/11

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F 281	<p>Continued From page 3</p> <p>on 10/27/11 at 3:40 PM, revealed on 10/08/11 and 10/09/11, she gave Resident #2 three (3) doses of Ativan 0.5 mg for increased anxiety. She stated she read the order to mean Ativan 0.5 mg two (2) times a day and as needed. She further stated after reading the order again she understood the order meant to give the Ativan two (2) times a day only.</p> <p>Observation of medication pass, on 10/27/11 at 9:00 AM, revealed the Biscoydal had not been initialed from 11/20/11 through 11/26/11. Interview with Registered Nurse #1 revealed the above order had been discontinued and the yellow highlighter used had come down over those five (5) blocks, so it appeared those days for the Biscoydal were marked out. RN #1 went to the resident's chart and checked the order and found the order had not been discontinued and there was no other orders to hold the medication.</p> <p>Interview with the Director of Nursing (DON), on 10/27/11 at 9:15 AM, revealed since the blocks had not been initialed they would assume the medication had not been given. She further stated after the medications were given the nurse was to initial the box to show the medication was given. She further stated the staff who had discontinued the above order should have rewritten the Biscoydal order since the yellow highlighter had come down onto the box's, making it appear as if those doses had been discontinued.</p> <p>Interview with the DON, on 10/28/11 at 4:00 PM, revealed LPN #2 had given an extra dose of Ativan 0.5 mg on 11/08/11 and 11/09/11. She further stated the staff were educated to do the</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>observations weekly for three months and monthly thereafter, routinely to assure that licensed staff meets professional standards. The Director of Nursing, will monitor through medication pass observation, Medication Administration Record review and consultant report review, at least monthly for three months, then at least quarterly, to assure professional standards of clinical practice are met. The results of the audits will be reviewed by the Performance Improvement Committee, comprised of the Executive Director, Director of Nursing, Medical Director, Staff Development Coordinator, Registered Dietician, Maintenance Director, Social Services Director, monthly for three months and then quarterly to assure professional standards of quality are followed. The Executive Director is responsible for overall compliance.</p>	11/19/11

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F 281	Continued From page 4 five (5) rights before giving any medications.	F 281		