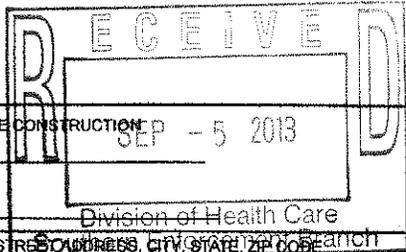


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Division of Health Care	(X3) DATE SURVEY COMPLETED  C 08/15/2013
NAME OF PROVIDER OR SUPPLIER  THE GRANDVIEW A NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719	

(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	Resident #1 was admitted to the facility on December 27, 2006. Upon admission Dr. Dixon was the physician. Resident's admitting diagnosis includes Renal Failure, Diabetes, Mellitus, and Hep C. Resident goes out of facility three days a week for dialysis.	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE  Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.  Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.  Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.  The written notice specified in paragraph (a)(4) of	F 203	Since admission there have been numerous discussions with resident and the family related to resident being non-compliant with his diet and insulin. After months of resident #1 being non-compliant and not following physician's orders, Dr. Dixon instructed resident to find another physician. On March 29, 2008, resident's care was turned over to Dr. Sztendera.  Resident #1 has continued to be non-compliant with their diet and the nursing staff has continued to re-educate resident on the importance of following the diet to better control the blood sugars.  On July 12, 2013, it was reported that there was a suspicion that Resident #1 was giving self-insulin injections and resident was keeping insulin and syringes in the room. The facility began an in house investigation at this time.	

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

*Andy Benin*

TITLE

*Administrator*

(X5) DATE

*9/5/13*

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 203	Continued From page 1 this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure the reason for a transfer or discharge was documented in the medical record for one of three sampled residents (Resident #1). The facility issued a written notice on 07/18/13 of the intent to discharge Resident #1 from the facility on 08/17/13; however, the facility failed to document the reason for the resident's discharge in the resident's clinical record.  The findings include:  A review of the facility's policy titled, "Transfer/Discharge," dated 01/09/03, revealed the facility would document in the resident's medical record the basis for the transfer or discharge, and the documentation would be	F 203	A black glucometer bag was found lying out on a bookshelf in resident #1 room. Found inside the bag was insulin that was different from the prescribed insulin that resident #1 is to take. Along with used insulin syringes and a glucometer.  We continued the investigation and assessed our concerns:  <ul style="list-style-type: none"> <li>• Taking insulin while out of the facility that is different than what is prescribed to resident.</li> <li>• Nurses not knowing that resident has given self an insulin injection and the nurse gives resident an injection and resident codes related to mixing the two insulin's or due to receiving too much insulin.</li> <li>• Risk of another resident entering resident's room and possibly self-injecting with a dirty needle.</li> </ul>		

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F 203	<p>Continued From page 2</p> <p>made by the resident's attending physician if the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 08/13/12, with diagnoses including Glaucoma, Diabetes Mellitus, and End Stage Renal Disease. On the day of the visit, 08/15/13, Resident #1 continued to reside in the facility; however, the resident was out of the facility for a medical appointment and unavailable for interview.</p> <p>A review of a facility investigation timeline and the discharge notice issued to Resident #1 on 07/18/13 revealed the facility had learned Resident #1 was keeping a vial of insulin and syringes in his/her room to take with him/her when out of the facility. According to the investigation, whoever was accompanying Resident #1 was utilizing the insulin/syringes to medicate the resident when clinically indicated. Subsequently, the facility made the decision to discharge Resident #1 based on the investigation stating, "the needs of the resident can no longer be met at the facility and the resident is non-compliant with care." However, a review of Resident #1's medical record revealed the facility failed to document the reason for discharge in Resident #1's medical record.</p> <p>An interview with Resident #1's physician on 08/15/13, at 12:30 PM revealed the facility had informed her of their intentions to discharge Resident #1 from the facility on 07/12/13. However, the physician stated she was not in agreement with the discharge notice and believed the facility could fully meet all of Resident #1's</p>	F 203	<p>The facility feels there is justification for discharge based on the following:</p> <ul style="list-style-type: none"> <li>The needs of the resident can no longer be met at the facility.....<u>resident #1 is non-compliant with care. Resident #1 is self-medicating with someone else's insulin and this is not the prescribe insulin for this resident. If the facility knowingly allows resident #1 to continue then the facility is putting the resident and the facility at risk for jeopardy.</u></li> <li>Safety of individuals in the facility may be endangered and resident's safety endangered due to non-compliance.....<u>there is a possible risk of another resident going into resident's room and getting the insulin and the needles causing harm to self. Resident is also causing self-harm; as well as endangering his nurse's career. If a nurse gives resident insulin and not aware what resident has received while out; being it too much insulin or the wrong insulin, this could cause the resident to code resulting in death. If this should happen it is going to appear that the nurse is at fault.</u></li> </ul>		

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F 203	<p>Continued From page 3</p> <p>needs and stated the resident displayed no danger to self or others. Resident #1's physician went on to state she did not have a problem with Resident #1 being administered insulin when indicated while off grounds by an accompanying individual. However, the physician indicated no efforts were put forth by the facility to implement any possible alternative to discharging Resident #1.</p> <p>Interview with the Social Worker on 08/15/13, at 11:40 AM, revealed the facility had made the decision on 07/12/13 to discharge Resident #1 after the insulin and syringes were discovered in the resident's room. The Social Worker stated the facility did meet with Resident #1 and his/her Power of Attorney to inform them of the facility's concerns and intentions to discharge Resident #1 from the facility. The Social Worker stated that although Resident #1 and the Power of Attorney stated they did not want the discharge to occur, and indicated the resident would no longer keep insulin in his/her room, the facility did not feel Resident #1 would remain compliant "based on [his/her] history," and informed the resident and Power of Attorney of their intentions to discharge Resident #1 from the facility. The Social Worker stated the facility failed to consider other alternatives through care planning or initiate multi-disciplinary interventions in an attempt to meet the resident's needs. The Social Worker stated the reason for Resident #1's discharge from the facility was not recorded in the resident's medical record by the attending physician because the physician was not in agreement with discharging Resident #1 from the facility.</p> <p>On the day of the investigation, the Administrator was not at the facility; however, the investigative</p>	F 203	<p><i>This decision was not made lightly as it is not our practice of issuing discharge notices. There was a lot of thought and discussion prior to issuing the notice. We continue to feel that it is in the best interest of the resident and the facility if resident is discharged. As of this date, September 5, 2013, the resident remains in the facility.</i></p>		

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F 203	Continued From page 4 findings were discussed with the Administrator via phone on 08/15/13.	F 203	The Grandview Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.  The Grandview Nursing and Rehab reserves all rights to contest the survey findings through informal dispute resolutions, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. The Grandview Nursing and Rehabilitation reserves all rights to raise all possible contentions and criminal claim, action or proceeding. Nothing contained in this plan of corrections should be considered as a waiver of any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which The Grandview Nursing and Rehabilitation does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Grandview Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to residents.		

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F 203	Continued	F 203	<p><b>483.12 (a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGED</b></p> <p>It is and was on the day of an recent abbreviated standard survey, the policy and practice of The Grandview Nursing and Rehabilitation Facility, to notify the resident and family of a transfer or discharge. As well as giving notification of the reason for the transfer or discharge. The reason for the transfer or discharge is also noted in the resident's record.</p> <ol style="list-style-type: none"> <li>1. The reason for the discharge is document in resident #1 chart.</li> <li>2. There have not been any other involuntary discharges notices issued.</li> <li>3. The charted information of any involuntary discharge will be filed in the residents chart. The Director of Nursing and the Social Service Director will review the chart of any potential discharges to ensure all interventions have been attempted prior to transfer/discharge letter being sent.</li> <li>4. The Administrator or Director of Nursing will review the chart for reason of discharge of any involuntary discharge from the facility when a discharge notice is issued.</li> </ol>	9/5/13	