

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

PRINTED: 10/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 SHEPHERD LANE BEDFORD, KY 40006		
(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	November 4, 2013 F 157		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	1) The identified resident was discharged from the facility on September 18, 2013. 2) All residents within the facility had the last 30 days of physician orders reviewed by November 1, 2013 by the DON and ADONs to identify any times of non-notification related to an accident involving the resident which resulted in an injury and has the potential for requiring physician intervention: a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility or a		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X* TITLE *X* (X6) DATE *X 10/26/13*

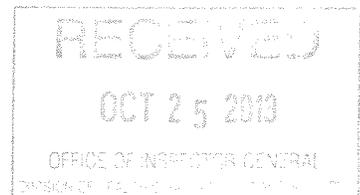
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
OCT 25 2013
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to notify a family of a medication change for one (1) or four (4) sampled residents. Resident #1 had Meprobamate discontinued on 09/07/13 and it was not reported to the family until 09/09/13.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Physician Orders At-A-Glance, revealed after a physician order was obtained, the order should be placed on the Medication Administration Record and the medication order faxed to the pharmacy. The family/POA should be notified via telephone.</p> <p>Review of Resident #1's medical record revealed an order was written to discontinue Meprobamate on 09/07/13. On 09/09/13 the nurse's note revealed the family was notified the Meprobamate was discontinued. The family expressed concern the medication had been discontinued. The Meprobamate was restarted by physician on 09/09/13.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 10/08/13 at 4:41 PM, revealed if a medication was changed the family should have been notified and the notification documented. If a nurse were unable to contact the family that would also be documented. The ADON stated on 09/09/13 she reviewed the physician's orders from the weekend and noticed the discontinue order for the Meprobamate for Resident #1 and</p>	F 157	<p>change in room or roommate assignment. Residents found to have been affected by this deficient practice had themselves or their legal representative or interested family member notified by the DON or ADONs by November 1, 2013.</p> <p>3) On 10/10/13 the Administrator, Director of Nursing and Regional RN reviewed the policy regarding Physician Orders. By 10/14/13 all facility nurses were in-serviced by the Director of Nursing or one of the two Assistant Director of Nursing utilizing the Physician Orders policy regarding the importance of notifying the resident, their responsible party/family or POA of when a physician changes or alters a medication.</p>	



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F 157	Continued From page 2 also noticed there was no documentation the family had been notified. She then notified the POA about the medication change and he stated his sister would not be happy. The ADON informed him, he could call the physician, if she had any concerns. Later that same day the physician reordered the Meproamate for Resident #1. Interview with the Director of Nursing (DON), on 10/09/13 at 11:17 AM, revealed families are notified whenever there was a significant change, a fall, abnormal tests or with any medication change. Resident #1 had a medication change on 09/07/13 and the family should have been notified that date. She stated there was no documentation indicating an attempt to notify the family. The family was notified on 09/09/13 of the medication change and the family was upset and had the medication restarted by the physician. The reason for notifying the family with changes was to keep families updated on resident's conditions, she was not sure why the notification was not done on 09/07/13 as per the policy. It would have prevented family dissatisfaction.	F 157	4) An audit will be kept by the assistant directors of nursing and week-end mangers of when a physician's order is found that a family\responsible party or POA was not notified. That audit will be reviewed by the director of nursing weekly. If more than 5 orders were found to not have been called/notified to the resident family\responsible party or POA the nursing staff will receive additional in-servicing. The director of nursing will report monthly to the QAPI committee of the findings of the audit. An audit will be completed weekly by the Administrator, Chaplain, or DON on 10 resident charts per week for 3 months to ensure that the responsible party/family or POA have been notified in a timely manner. The results of this audit will be given to the director of nursing for one on one education with the nursing staff responsible up to disciplinary action as warranted. Findings of the chart audit will be reviewed in the QAPI meeting monthly for 3 months and then at the discretion of the QAPI committee.	

