

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

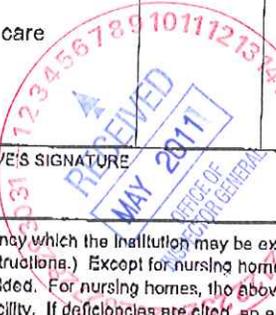
PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
--	--

(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 (KY #16234) was conducted on 04/05/11-04/12/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D". KY #16234 was unsubstantiated with an unrelated deficiency cited at F280.	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, it was determined the facility failed to identify declines in the physical and mental status for one resident (#3), in the selected sample of seven, which required a Minimum Data Set (MDS) significant change assessment and interdisciplinary review and revision of the care plan. Findings included:	F 274	<u>F274</u> <u>483.20(b)(2)(ii) Comprehensive Assessment After Significant Change</u> It is the routine practice of Spring View Health and Rehab to conduct a comprehensive assessment of a resident within 14 days after the facility has determined that there has been a significant change in the resident's physical or mental condition. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #3 had a significant change MDS completed on 04/07/2011 by the MDS Coordinator. <u>How other residents who may have been affected by this practice were identified:</u> The MDS's of the remaining residents in the facility will be reviewed by the MDS Coordinator and the Director of Nursing to verify that the current MDS is an accurate assessment type for the resident, to identify others who may be at risk. This will be completed by 05/11/2011. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The MDS Coordinator was re-educated by the Director of Nursing and the Quality Management Nurse on 05/02/2011 on the criteria that indicates a significant change assessment is to be completed for the resident	05/13/2011



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: LNHA (X6) DATE: 5/3/11

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.

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

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2011
NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	
(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 274	<p>Continued From page 1</p> <p>A record review revealed Resident #3 was admitted on 06/29/10 and readmitted on 08/08/10, with diagnoses to include End Stage Renal Disease and a History of Endometrial Cancer.</p> <p>A review of the quarterly MDS, dated 10/17/10, revealed the resident had experienced declines in the areas of cognition, behaviors, transfers, ambulation, dressing, eating, personal hygiene and continence status.</p> <p>A review of the admission assessment, dated 07/10/10, revealed the facility identified Resident #1 as independent in cognition. A review of the quarterly assessment, dated 10/17/10, revealed the resident rarely to never understood and was unable to complete the "Brief Interview for Mental Status" (BIMS.) The resident was previously assessed as free of symptoms of delirium, however, now the resident experienced inattention, disorganized thinking and an altered level of consciousness. Resident #3 previously had no behavior and was assessed during the quarterly review as short tempered and easily annoyed, nearly every day and had rejected care, one to three days out of seven. The resident also experienced declines in transfer, ambulation in the room and in the hallway, dressing, eating, personal hygiene and incontinence.</p> <p>An interview with the MDS Coordinator, on 04/07/11 at 10:00 AM, revealed after a review of the admission MDS, dated 07/10/10 and the quarterly MDS, dated 10/17/10, a Significant Change Assessment should have been completed as there had been a decline in two or more care areas.</p>	F 274	<p><u>F274 (Continued)</u></p> <p>by the MDS Coordinator in accordance with the MDS manual.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The Director of Nursing will conduct an audit of 6 (approximately 10%) residents MDS's monthly X 6 months to verify that the appropriate assessment type has been completed on those residents. The results of the audits will be reported to the administrator and the facility's Quality Assurance Committee.</p> <p>If any areas of concern are identified, the frequency and/or number of the audits being conducted will be increased, or conversely, if no areas of concern are identified the number and/or frequency may be decreased.</p>	

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

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1B5309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
--	--

(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 274	Continued From page 2 An interview with the Director of Nursing, on 04/07/11 at 10:50 AM, revealed, "It should have been done."	F 274		
F 280 SS=D	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. 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 interview and record review, it was determined the facility failed to ensure a comprehensive care plan was initiated for three residents (#1, #3 and #7), in the selected sample of seven, related to fluid needs as determined by the dialysis center. Findings include: A review of the Nursing Home Dialysis Transfer	F 280	<u>F280</u> <u>483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise Care Plan</u> It is the normal practice of Spring View Health and Rehab to develop a comprehensive care plan prepared by the interdisciplinary team, that includes the attending physician, a registered nurse with the responsibility for the resident, and other appropriate staff in disciplines as determined by the residents 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. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident # 1 had expired, so no corrective measures available. Resident # 3 has since expired, so no corrective measures available. Resident #7 was discharged home and no longer in the facility, so no corrective measures available. <u>How other residents who may have been affected by this practice were identified:</u> Residents who receive dialysis have the potential to be affected. Currently there are no residents in the facility that are receiving dialysis.	05/13/2011

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

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
--	--

(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 280	<p>Continued From page 3</p> <p>Agreement, dated 01/01/11, revealed the dialysis center was to develop and implement a care plan relative to the provision of dialysis services and to have a designated person at the facility to be utilized as an oversight of these provisions.</p> <p>1. Resident #1 was admitted on 01/03/11 and readmitted on 01/28/11, with diagnoses to include End Stage Renal Disease (ESRD), Renal Cell Carcinoma and Renal Dialysis. A review of the admission MDS, dated 01/16/11, revealed the resident was fed through a feeding tube and was assessed as totally dependent on staff members for all care needs.</p> <p>A review of the nutritional record, dated 03/03/11, revealed the facility identified the resident's estimated fluid need was between 1578 milliliters (ml) and 2250 ml per day.</p> <p>A review of the of the care plans for "fluid volume overload" and "risk of dehydration", dated 02/14/11, revealed interventions included observation for signs and symptoms of edema, shortness of air and dehydration. The resident was scheduled for dialysis treatment on Monday, Wednesday and Friday. However, the facility did not ensure the dialysis center provided their care plan with identification of expectation for the resident's daily fluid need.</p> <p>2. Resident # 3 was admitted on 06/29/10 and readmitted on 08/08/10, with diagnoses to include ESRD, Renal Dialysis and Chronic Heart Failure. A review of the annual MDS assessment, dated 01/18/11, revealed the resident was assessed as requiring extensive assistance with care needs.</p> <p>A review of the estimated fluid needs, dated</p>	F 280	<p><u>F280 (Continued)</u></p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The contracted dialysis center will provide a copy of the initial physician orders and any updated physician orders related to fluid needs for residents who receive dialysis, to the facility to be incorporated into the resident's comprehensive plan of care. The physician orders related to fluid needs will be sent back with the resident to the facility upon transfer from the dialysis center.</p> <p>All care plans that are provided will be integrated in the residents comprehensive plan of care.</p> <p>The licensed nursing staff will be in-serviced on the new process by 05/12/2011 by the director of nursing/ADON or LPN supervisor. The DON will be responsible to provide or arrange for inservicing for any licensed nurse who has not completed the session by 05/12/2011 prior to their next shift worked.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The director of nursing/ADON or MDS Coordinator will review the medical record and care plans weekly X 6 months, on residents who are receiving dialysis to verify ongoing compliance. The results of the all audits will be reported to the facility's Quality Assurance Committee. If any areas of concern are identified, the number and/or frequency of the audits will be increased. Conversely, if no issues are identified, the number and/or frequency may be decreased.</p>	
-------	--	-------	---	--

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

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/12/2011
NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754		
(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 280	<p>Continued From page 4</p> <p>02/17/11, revealed the resident needed extensive assistance with meals, had a decline in appetite, needed much encouragement to consume foods or fluids and required at least 1198 ml of fluid a day or greater.</p> <p>A review of care plans for "fluid volume at risk" and "nutrition at risk", dated 11/1/10, revealed interventions did not include the dialysis center's expectations regarding the resident's daily fluid need.</p> <p>3. Resident #7 was admitted on 08/13/10, with diagnoses to include Orthopedic Aftercare due to a Motor Vehicle Accident (MVA,) Chronic Renal Failure and Fractures of the Ribs and Right Ankle. A review of the admission MDS, dated 08/25/10, revealed the resident was assessed to require extensive assistance with bed mobility, was unable to ambulate and was able to feed him/herself with tray set-up.</p> <p>A review of the dietician's estimated fluid needs, dated 08/20/10, revealed the resident was on a 1200 ml per day, fluid restriction. A review of the care plans for "nutrition and fluid volume at risk", dated 08/31/10, revealed no care plans developed by the dialysis center was included.</p> <p>An interview on 04/08/11 at 11:40 AM with the Administrator and the Director of Nursing (DON,) revealed she was unaware the dialysis was to have provided a care and the facility was to have developed their care plan by utilizing the center's recommendations.</p>	F 280			

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

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2011
--	--	--	---



NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
--	--

(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 An abbreviated survey (KY #16234) was conducted on 04/05/11-04/12/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D". KY #16234 was unsubstantiated with an unrelated deficiency cited at F280.	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 274 SS=D	483.20(b)(2)(II) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, it was determined the facility failed to identify declines in the physical and mental status for one resident (#3), in the selected sample of seven, which required a Minimum Data Set (MDS) significant change assessment and interdisciplinary review and revision of the care plan. Findings included:	F 274	<u>F274</u> <u>483.20(b)(2)(ii) Comprehensive Assessment After Significant Change</u> It is the routine practice of Spring View Health and Rehab to conduct a comprehensive assessment of a resident within 14 days after the facility has determined that there has been a significant change in the resident's physical or mental condition. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #3 had a significant change MDS completed on 04/07/2011 by the MDS Coordinator. <u>How other residents who may have been affected by this practice were identified:</u> The MDS's of the remaining residents in the facility will be reviewed by the MDS Coordinator and the Director of Nursing to verify that the current MDS is an accurate assessment type for the resident, to identify others who may be at risk. This will be completed by 05/11/2011. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The MDS Coordinator was re-educated by the Director of Nursing and the Quality Management Nurse on 05/02/2011 on the criteria that indicates a significant change assessment is to be completed for the resident	05/13/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

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.

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

 PRINTED: 04/27/2011
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/12/2011
NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY, 42754		
(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 274	<p>Continued From page 1</p> <p>A record review revealed Resident #3 was admitted on 06/29/10 and readmitted on 08/08/10, with diagnoses to include End Stage Renal Disease and a History of Endometrial Cancer.</p> <p>A review of the quarterly MDS, dated 10/17/10, revealed the resident had experienced declines in the areas of cognition, behaviors, transfers, ambulation, dressing, eating, personal hygiene and continence status.</p> <p>A review of the admission assessment, dated 07/10/10, revealed the facility identified Resident #1 as Independent in cognition. A review of the quarterly assessment, dated 10/17/10, revealed the resident rarely to never understood and was unable to complete the "Brief Interview for Mental Status" (BIMS.) The resident was previously assessed as free of symptoms of delirium, however, now the resident experienced Inattention, disorganized thinking and an altered level of consciousness. Resident #3 previously had no behavior and was assessed during the quarterly review as short tempered and easily annoyed, nearly every day and had rejected care, one to three days out of seven. The resident also experienced declines in transfer, ambulation in the room and in the hallway, dressing, eating, personal hygiene and incontinence.</p> <p>An interview with the MDS Coordinator, on 04/07/11 at 10:00 AM, revealed after a review of the admission MDS, dated 07/10/10 and the quarterly MDS, dated 10/17/10, a Significant Change Assessment should have been completed as there had been a decline in two or more care areas.</p>	F 274	<p><u>F274 (Continued)</u></p> <p>by the MDS Coordinator in accordance with the MDS manual.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The Director of Nursing will conduct an audit of 6 (approximately 10%) residents MDS's monthly X 6 months to verify that the appropriate assessment type has been completed on those residents. The results of the audits will be reported to the administrator and the facility's Quality Assurance Committee.</p> <p>If any areas of concern are identified, the frequency and/or number of the audits being conducted will be increased, or conversely, if no areas of concern are identified the number and/or frequency may be decreased.</p>		

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

 PRINTED: 04/27/2011
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2011
NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	
(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 280	<p>Continued From page 3</p> <p>Agreement, dated 01/01/11, revealed the dialysis center was to develop and implement a care plan relative to the provision of dialysis services and to have a designated person at the facility to be utilized as an oversight of these provisions.</p> <p>1. Resident #1 was admitted on 01/03/11 and readmitted on 01/28/11, with diagnoses to include End Stage Renal Disease (ESRD); Renal Cell Carcinoma and Renal Dialysis. A review of the admission MDS, dated 01/16/11, revealed the resident was fed through a feeding tube and was assessed as totally dependent on staff members for all care needs.</p> <p>A review of the nutritional record, dated 03/03/11, revealed the facility identified the resident's estimated fluid need was between 1578 milliliters (ml) and 2250 ml per day.</p> <p>A review of the of the care plans for "fluid volume overload" and "risk of dehydration", dated 02/14/11, revealed interventions included observation for signs and symptoms of edema, shortness of air and dehydration. The resident was scheduled for dialysis treatment on Monday, Wednesday and Friday. However, the facility did not ensure the dialysis center provided their care plan with identification of expectation for the resident's daily fluid need.</p> <p>2. Resident # 3 was admitted on 08/29/10 and readmitted on 08/08/10, with diagnoses to include ESRD, Renal Dialysis and Chronic Heart Failure. A review of the annual MDS assessment, dated 01/18/11, revealed the resident was assessed as requiring extensive assistance with care needs.</p> <p>A review of the estimated fluid needs, dated</p>	F 280	<p><u>F280 (Continued)</u></p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The contracted dialysis center will provide a copy of the initial physician orders and any updated physicians orders related to fluid needs for residents who receive dialysis, to the facility to be incorporated into the resident's comprehensive plan of care. The physician orders related to fluid needs will be sent back with the resident to the facility upon transfer from the dialysis center.</p> <p>All care plans that are provided will be integrated in the residents comprehensive plan of care.</p> <p>The licensed nursing staff will be in-serviced on the new process by 05/12/2011 by the director of nursing/ADON or LPN supervisor. The DON will be responsible to provide or arrange for inservicing for any licensed nurse who has not completed the session by 05/12/2011 prior to their next shift worked.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The director of nursing/ADON or MDS Coordinator will review the medical record and care plans weekly X 6 months, on residents who are receiving dialysis to verify ongoing compliance. The results of the all audits will be reported to the facility's Quality Assurance Committee. If any areas of concern are identified, the number and/or frequency of the audits will be increased. Conversely, if no issues are identified, the number and/or frequency may be decreased.</p>	

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

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
--	--

(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 274	Continued From page 2. An interview with the Director of Nursing, on 04/07/11 at 10:50 AM, revealed, "it should have been done."	F 274		
F 280 SS=D	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. 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 interview and record review, it was determined the facility failed to ensure a comprehensive care plan was initiated for three residents (#1, #3 and #7), in the selected sample of seven, related to fluid needs as determined by the dialysis center. Findings include: A review of the Nursing Home Dialysis Transfer	F 280 <u>483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise Care Plan</u> It is the normal practice of Spring View Health and Rehab to develop a comprehensive care plan prepared by the interdisciplinary team, that includes the attending physician, a registered nurse with the responsibility for the resident, and other appropriate staff in disciplines as determined by the residents' 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. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident # 1 had expired, so no corrective measures available. Resident # 3 has since expired, so no corrective measures available. Resident #7 was discharged home and no longer in the facility, so no corrective measures available. <u>How other residents who may have been affected by this practice were identified:</u> Residents who receive dialysis have the potential to be affected. Currently there are no residents in the facility that are receiving dialysis.	05/13/2011	

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

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
--	--

(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 280	<p>Continued From page 4</p> <p>02/17/11, revealed the resident needed extensive assistance with meals, had a decline in appetite, needed much encouragement to consume foods or fluids and required at least 1198 ml of fluid a day or greater.</p> <p>A review of care plans for "fluid volume at risk" and "nutrition at risk", dated 11/1/10, revealed interventions did not include the dialysis center's expectations regarding the resident's daily fluid need.</p> <p>3. Resident #7 was admitted on 08/13/10, with diagnoses to include Orthopedic Aftercare due to a Motor Vehicle Accident (MVA,) Chronic Renal Failure and Fractures of the Ribs and Right Ankle. A review of the admission MDS, dated 08/25/10, revealed the resident was assessed to require extensive assistance with bed mobility, was unable to ambulate and was able to feed him/herself with tray set-up.</p> <p>A review of the dietitian's estimated fluid needs, dated 08/20/10, revealed the resident was on a 1200 ml per day, fluid restriction. A review of the care plans for "nutrition and fluid volume at risk", dated 08/31/10, revealed no care plans developed by the dialysis center was included.</p> <p>An interview on 04/08/11 at 11:40 AM with the Administrator and the Director of Nursing (DON,) revealed she was unaware the dialysis was to have provided a care and the facility was to have developed their care plan by utilizing the center's recommendations.</p>	F 280		
-------	--	-------	--	--