

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

PRINTED: 08/07/2012
FORM APPROVED
OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/01/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
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F 000	INITIAL COMMENTS An abbreviated survey was initiated on 07/30/12 and concluded on 08/01/12 to investigate KY18554. The Division of Healthcare unsubstaniated KY18554; however, unrelated deficiencies were cited.	F 000	Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 329	F 329 D 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was evaluated by the physician on 8-2-2012 and reviewed by the Interdisciplinary team on 8-9-2012 for the appropriate use of the anxiolytic medication Klonopin. The MD noted tremors and jerking and continued the use of the Klonopin. The resident was also seen on August 20, 2012 by a Neurologist who also agreed with the current treatment plan.	Sept 3

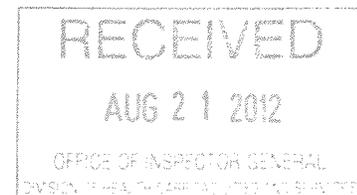
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bill Mueller</i>	TITLE <i>x Executive Director</i>	(X6) DATE <i>x 8/21/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may 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 329	<p>Continued From page 1</p> <p>and review of the facility's policy Medication Monitoring, Medication Management, it was determined the facility failed to ensure one (1) of the five (5) sampled residents (Resident #1) was free of unnecessary drugs. Resident #1 was restarted on the Anxiolytic medication Klonopin, without being seen by the Physician for one hundred ten (110) days, and without exhibiting symptoms.</p> <p>The findings include:</p> <p>Review of the facility's policy Medication Monitoring, Medication Management, dated 10/2007, revealed the nursing care center establishes monitoring guidelines for managing medications to promote their safe and effective use and to prevent potential adverse consequences. The nursing care center staff, attending physicians and prescribers and the consultant pharmacist, performs this process. Residents receive medications only if ordered by the prescriber. The medical necessity is documented in the resident's medical record and in the care planning process. Initiation and dosing of medications follows recommendation from the medical literature, standards of practice, and regulations. The following conditions are satisfied prior to initiation and/or continuation of therapy: Possible reversible causes for the resident's condition have been ruled out; Use results in maintenance or improvement in the resident's functional status; The need for and response to therapy are monitored and documented in the resident's medical record.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident with the following</p>	F 329	<p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? Residents receiving anxiolytic and antipsychotic medications were reviewed for the appropriate diagnosis and indications for use by the IDT by August 24, 2012. If diagnosis and indications for use do not warrant the continued use of the medication the physician will be notified by the Director of Nursing by August 30, 2012.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education was provided by the Director of Clinical Education to the Licensed Nursing staff on unnecessary drugs, including anxiolytic drugs. In addition Licensed Nursing staff was inserviced on adequate monitoring. This training was completed by August 31, 2012. The Medical Director issued a letter to attending MDs and APRNs containing education for the F 329 regulation and August 24, 2012.</p>		



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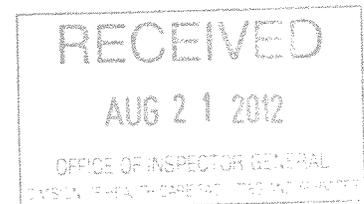
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F 329	<p>Continued From page 2</p> <p>diagnoses: Alzheimer's; Dementia; Psychosis; and Depression. Review of the resident's neurology consult, dated 07/16/08, revealed the resident was having episodes of twitching in her upper extremities and had no history of seizures. The neurologist started the resident on Klonopin 0.25 mg twice a day, and asked the resident to return as needed. The facility was unable to provide evidence the resident had a follow up with the neurologist since the consultation in 2008. The resident was last seen by psychiatry on 07/11/11. The resident began Hospice care August, 2011.</p> <p>Continued review of the clinical record revealed the facility's consultant pharmacist completed a monthly review on October, 2011 with recommendations the resident was due an anxiolytic drug evaluation, per CMS guidelines pertaining to use in elderly, and to please consider a gradual dose reduction. The Advanced Practice Nurse Practitioner (ARNP), on 10/31/11, decreased the Klonopin to 0.25 mg at bedtime. Review of the Consultant Pharmacist Communication to the Physician dated February, 2012 revealed a recommendation for a trial reduction of Klonopin, then a trial of discontinuation. On 02/28/12, the ARNP agreed with gradual dose reduction and the medication was discontinued on 03/12/12. Review of the Physicians progress notes, dated 03/28/12, revealed the ARNP's impression was the resident was stable with no change.</p> <p>Observations of Resident #1, on 7/30/12 at 4:45 PM, and on 7/31/12 at 8:50 AM, 8:55 AM, 9:00 AM, 10:45 AM, 11:40 AM, 12:30 PM, 1:30 PM, 4:00 PM, and 5:00 PM revealed neither tremors</p>	F 329	<p>4) How will the facility monitor its performance to ensure that solutions are sustained?</p> <p>The Consultant Pharmacist will audit active residents for unnecessary drugs by August 25, 2012 and then continue monthly.</p> <p>Upon completion of the Consultant Pharmacist audit, results from the audit will be discussed with the DNS, ED, and Medical Director. The Director of Nursing and ED will monitor these results monthly through the Consultant Pharmacist visit report and the Director of Nursing will report problems and/or trends to the facility QAA committee monthly for 3 months, then quarterly thereafter.</p>	
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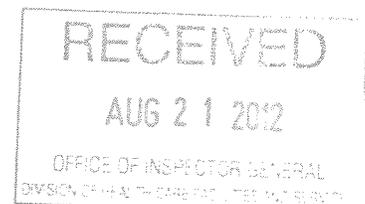
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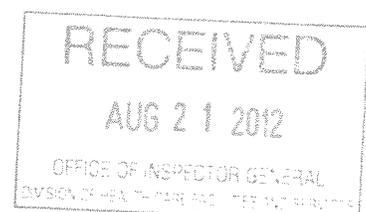
F 329	<p>Continued From page 3</p> <p>to extremities, nor any attempt by the resident to move or reposition self.</p> <p>Review of the resident's nursing notes revealed, on 04/30/12, the resident's daughter reported a concern of a spastic body movement noted from the resident and wanted to know what she could do to get the Klonopin restarted.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/01/12 at 2:55 PM, revealed on 04/30/12 the daughter walked into the dining room and touched the resident, from behind, on the shoulder. The LPN revealed the resident jumped as if startled and the daughter started "going off" and said she wanted the medicine [Klonopin] restarted. The LPN revealed it was her nursing opinion the resident did not need the medicine, related to not exhibiting any symptoms. The LPN revealed she did not see a difference when the resident was on the medication, except for being more sleepy. The LPN revealed that as people age their needs change.</p> <p>Review of Resident #1's nursing notes, dated 05/04/12, revealed the Unit Manager (UM) had received a phone call from the daughter inquiring about the discontinuation of the Klonopin. The UM wrote in the notes she reviewed the residents medications, noted the discontinuation of the medicine and called the Physician's office.</p> <p>Interview with the Unit Manager, on 08/01/12 at 2:30 PM, revealed the daughter had called asking to restart the resident seizure medication. The UM revealed she told the daughter the resident did not have a diagnosis of Seizures and was not sure what medicine she was talking about. The</p>	F 329		
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F 329	<p>Continued From page 4</p> <p>UM revealed the daughter became very upset. The UM revealed this conversation prompted her to look at medications to see what had been discontinued. The UM revealed she called the Physician's office to request the medication because of the daughter's behavior and her frequent demands. The UM revealed she did not think the Klonopin should have been restarted, but felt harassed by administration to bend to the needs of the daughter.</p> <p>Review of the Physicians script, provided by pharmacy, revealed Klonopin was restarted on 05/04/12 at 0.25 mg to be given in the evening.</p> <p>Review of the nursing notes, dated 05/21/12, revealed the daughter requested the Klonopin be increased to 0.25 mg twice a day and the order was increased per telephone order.</p> <p>Review of the nursing notes, dated 05/24/12, revealed difficulty feeding the resident lunch due to the resident sleeping during the meal. The nursing note, dated 05/25/12, revealed the resident was having increased lethargy and was not able to eat. The Director of Nursing (DON) called the daughter to give an update and suggested they decreased the Klonopin to 0.25 mg at bedtime as it was before. The daughter refused and requested the medication be decreased to 0.125 mg twice a day. Review of the Facsimile Transmission to the Physician, dated 05/25/12, revealed the resident was on 0.25 mg at bedtime then increased to twice a day at the request of the daughter. The resident had increased lethargy. When staff spoke to the resident's daughter about putting the medicine back to what it was, the daughter refused and</p>	F 329			



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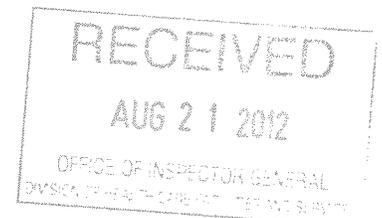
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F 329	<p>Continued From page 5</p> <p>stated she wanted the medicine cut in half to 0.125 mg twice a day. Review of the Physician's script, dated 05/26/12, revealed the medicine had been reduced per the daughter's request.</p> <p>Review of the Physician's progress notes revealed the resident was not seen or assessed by a Physician or provider from 03/29/12 to 7/16/12 for need, dose, or frequency of the medication.</p> <p>Interview with the Physician, on 08/01/12 at 3:47 PM, revealed the medication was restarted due to the demands of the Resident's daughter. In addition, the Physician revealed the Resident should have been seen by him and not the ARNP. The Physician revealed the resident was supposed to be seen by the Physician every sixty (60) days.</p> <p>Interview with the Director of Nursing (DON), on 08/01/12 at 4:10 PM, revealed the daughter started complaining about the medicine being discontinued in May, several months after the medication had been reduced and discontinued. The DON revealed she did not notice, or know of any symptoms and did not think the resident required the medicine. However, the DON revealed the daughter complained and they called the Physician to restart the medication. The DON revealed she did call the Resident's daughter on, 05/25/12 to discuss the medication, staff concerns about the resident being lethargic, and if they could make adjustments to the medication. The DON revealed she should have called the Physician first to discuss concerns and medication needs of the resident, and not the Resident's daughter.</p>	F 329		
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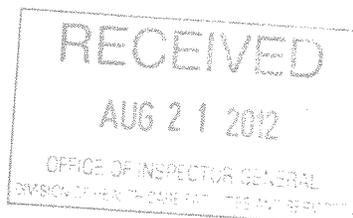
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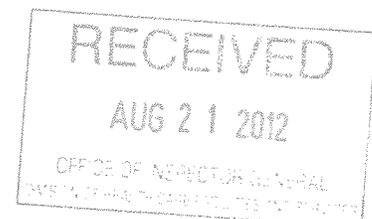
F 329	Continued From page 6 Interview with the Administrator, on 08/01/12 at 5:30 PM, revealed he had not reviewed the Resident's clinical record and would not give a clinical opinion. However, the Administrator revealed his responsibility was patient care.	F 329		
F 387 SS=D	<p>See F387</p> <p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure one (1) of the five (5) sampled residents (Resident #1) were seen by a Physician at least every sixty days. Resident #1 was not seen by a Physician for one hundred ten (110) days, which is forty (40) days past the requirement.</p> <p>The finding include: Review of Resident #1's clinical record revealed the facility admitted the resident, on 08/31/07, with the following diagnoses: Alzheimer's; Dementia; Psychosis; and Depression. Review of the Physician progress notes revealed that the</p>	F 387	<p>F 387 D</p> <p><i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> Resident #1 was evaluated by the physician on 8-2-12.</p> <p><i>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> Current resident records were audited by the Unit Managers on 8-4-12. ARNP and MD visits were recorded on the Physician Visit Control Log. MDs were contacted by the Unit Managers, and needed visits were completed by the MDs by 8-24-12.</p>	Sept 3



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F 387	<p>Continued From page 7</p> <p>Advanced Registered Nurse Practitioner (ARNP) assessed the resident and wrote a progress note, on 03/28/12. The resident was not seen again until 07/16/12 by an ARNP.</p> <p>Interview with the Physician, on 08/01/12 at 3:47 PM, revealed he was aware residents should be seen every sixty (60) days. The Physician confirmed the resident was not seen in the required timeframe and revealed the resident should have been seen by him and not the ARNP. The Physician revealed the ARNP monitored when visits were to be completed; however, the ARNP went on a leave of absence. The Physician revealed there was a nurse that was trained to monitor when visits needed to be done, however, apparently the training was not sufficient.</p> <p>Interview with the Director of Nursing (DON), on 08/01/12 at 4:10 PM, revealed residents should be seen by a Physician at least every 60 days. The DON revealed Health Information Management (HIM) was responsible to monitor the timeliness of Physician visits.</p> <p>Interview with HIM, on 08/01/12 at 4:35 PM, revealed she did not keep track of Physician visits. The HIM revealed she performed random audits every month and looked at Physician progress note dates, but did not maintain a record of who was audited or kept track of when a resident should be seen by the Physician.</p> <p>Interview with Administrator, on 08/01/12 at 5:30 PM, revealed all residents were required to be seen by a Physician every 60 days. The Administrator revealed it was not HIM's</p>	F 387	<p>3) <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i></p> <p>The Monitoring Physician Visit policy was revised to designate the Unit Mangers as responsible for monitoring physician visits and notification to MDs about visits on August 20, 2012. Education was provided by the DNS on August 20, 2012 to the Unit Managers to review the Physician Progress notes monthly and update the Physician Visit Control log for MD and APRN visits; notify MDs of required upcoming visits per guidelines of 30 or 60 day visits and the need to alternate the APRN and MD visits; and notify the MD with a Delinquent Visit Notification Letter (via fax, mail or email) if the due date has been reached without the MD visiting. If a Physician or APRN is delinquent with visits, the Medical Director will be informed by the DNS and arrangements will be made for the patient to be seen within 48 hours by their physician, or the Medical Director will see the patient. The Medical Director sent a letter describing Physician visit requirements to each MD and APRN that is currently attending residents on August 24, 2012.</p>		



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F 387	Continued From page 8 responsibility to monitor, but the nursing department. The Administrator revealed the ARNP had been monitoring visits; however, during her leave of absence the facility assumed the responsibility. see F 329	F 387	4) How will the facility monitor its performance to ensure that solutions are sustained? The ADNS (DNS in the absence of the ADNS) will be audit 10% of the active resident population by reviewing MD progress notes, comparing to the Physician Visit Control log and determining if compliance has been achieved. Results of the audit will be discussed monthly with the DNS and ED. Using these results the ADNS will report problems and/or trends to the facility QAA committee monthly for 3 months, quarterly thereafter.	
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