

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

PRINTED: 12/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/29/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE AT COLONIAL REHAB &amp; WELLNESS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>708 BARTLEY AVENUE BARDSTOWN, KY 40004</b>
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(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
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/25/15 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185342	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/29/2015
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Name of Facility SIGNATURE HEALTHCARE AT COLONIAL REHAB & WELLNES	Street Address, City, State, Zip Code 708 BARTLEY AVENUE BARDSTOWN, KY 40004
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0203 Reg. # 483.12(a)(4)-(6) LSC	Correction Completed 12/25/2015	ID Prefix F0205 Reg. # 483.12(b)(1)&(2) LSC	Correction Completed 12/25/2015	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 12/25/2015
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 12/25/2015	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/25/2015	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 12/25/2015
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/25/2015	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 12/25/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By <i>my</i>	Reviewed By <i>VE</i>	Date: 12/30/15	Signature of Surveyor: <i>Mike Zornstein</i>	Date: 12/30/15
Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/3/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT COLONIAL REHAB & WELLNESS	STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004
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F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 12/01/15 and concluded on 12/03/15 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "D".  An Abbreviated Survey was initiated on 12/01/15 and concluded on 12/03/15 to investigate complaint KY24097. The Division of Health Care substantiated the allegation with related deficiencies cited.	F 000	The Plan of correction is the provider's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute agreement or admission of liability by the provider and such liability on part of the provider is hereby specifically denied. The submission of the plan does not constitute an agreement by the provider that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity of the deficiencies cited are correctly applied. The plan of correction is prepared and/or executed as required under federal and state regulations and statues applicable to long term care providers.	
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	F 203	1. Corrective action for the resident affected by the alleged deficient practice:  Resident 11 and 13 have returned to facility. A complete chart audit has been completed by corporate intermediary staff and education on transfer and discharge policy and procedure was done 12-2-15 with IDT.	12.25.15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *12-23-15*

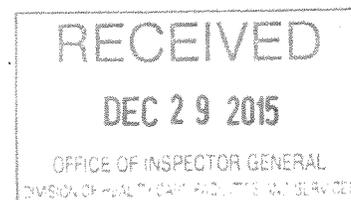
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

B.1B

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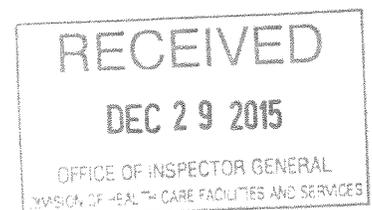
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F 203	Continued From page 1 (a)(2)(I) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.  The written notice specified in paragraph (a)(4) of 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 review of the facility's policy, it was determined the facility failed to provide a transfer/discharge notice to two (2) of fifteen (15) sampled residents. Residents # 11 and #13.  The findings include:  Review of the facility's policy regarding Transfer	F 203	2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:  All residents (62) in this facility had the potential to be affected by the alleged deficient practice. Education on proper transfer/discharge procedures per policy were given to all licensed nurses by staff development coordinator. All PRN nursing staff will have this in service before next working day.  3. Measures/Systematic changes put in place to assure the alleged deficient practice does not re occur:  DON/Unit Manager/SDC will conduct daily audits of all discharged/transferred residents Monday- Friday during morning stand-up meeting for correct procedure and documentation of residents being discharged or transferred from facility. The audits will consist of checking that appropriate documentation was given, responsible party was contacted, MD was contacted and SBAR was done before discharge/transfer. All inaccuracies will be addressed with immediate corrective actions and reeducation of licensed nursing staff.		



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F 203	<p>Continued From page 2</p> <p>and Discharge, dated 05/01/08, revealed the facility would provide a notice of transfer or discharge before the resident was transported, in writing, with the reason for the transfer and in a language and manner they understood. The policy instructed facility staff to complete the Notice of Transfer form and send a copy with the resident. The notice would include reason for the transfer or discharge, destination, physician and family notification, and the condition of the resident upon transfer or discharge. A copy of the notice would be placed in the medical record with documentation of circumstances surrounding the transfer or discharge.</p> <p>1. Review of the closed clinical record for Resident #13 revealed the facility admitted the resident on 02/27/15 with diagnoses of End Stage Renal Disease with Dependence on Dialysis, Diastolic Heart Failure, Bi-Polar Disorder, Anxiety, Tremors, and Chronic Pain.</p> <p>Review of previous Brief Interview for Mental Status (BIMS) test conducted with the Minimum Data Set (MDS) assessments on 03/06/15, 05/25/15, 08/14/15 revealed the resident scored a fifteen (15) each time. Continued review of the most current quarterly MDS assessment, dated 10/31/15, revealed the facility conducted a BIMS test with a score of fifteen (15) out of a possible fifteen (15), meaning the resident was cognitively intact.</p> <p>Continued review of the closed clinical record revealed the resident was transferred to an acute hospital on 11/23/15 and returned to the facility on 11/24/15 at 2:04 AM and a transfer notice was given.</p>	F 203	<p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not occur:</p> <p>IDT will review all discharged/transferred residents charts in morning stand-up meeting. If procedure is not 95% accurate, inaccuracies will be brought to monthly QAPI meeting for recommendations on proceeding.</p>		



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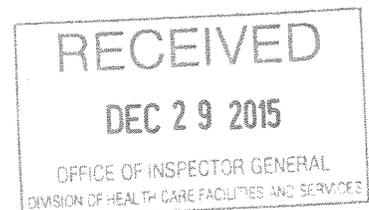
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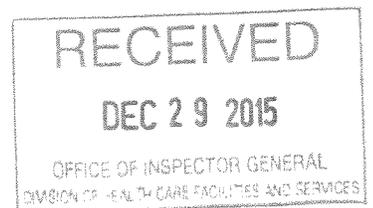
F 203	<p>Continued From page 3</p> <p>Review of a Social Service Progress Noted, dated 11/24/15 at 4:31 PM, revealed the resident was transported to an acute hospital and would be a direct admit to the Psych Unit related to behaviors exhibited during dialysis. There was no evidence a transfer notice was given.</p> <p>Interview with the Social Worker, on 12/02/15 at 10:58 AM, revealed a thirty (30) day notice was issued on 11/30/15 because the resident's responsible party did not want to pay for a bed hold. She stated the transfer and discharge notices are used interchangeably.</p> <p>Review of the thirty (30) day notice, issued on 11/30/15, revealed the facility informed the resident's responsible party they intended to discharge Resident #13 due to failure to comply with the plan of care and the facility was unable to meet the resident's needs. The right to appeal was included in the notice along with information of whom to contact and when. The date of discharge was 12/30/15. However, observation during the tour of the facility, on 12/01/15 at 8:35 AM, revealed another resident had already been placed in Resident #13's room. Refer to F205.</p> <p>Interview with the facility's Admission Coordinator, on 12/02/15 at 11:10 AM, revealed the thirty (30) day notice was issued because the family did not want to pay for a bed hold. She stated no transfer notice was given on 11/24/15.</p> <p>Interview with the Administrator, on 12/02/15 at 2:18 PM, revealed a transfer notice should have been issued and sent with the resident upon transfer.</p> <p>Interview with Resident #13's responsible party,</p>	F 203		
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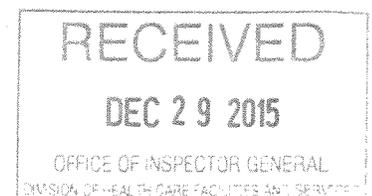
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F 203	<p>Continued From page 4</p> <p>on 12/03/15 at 2:24 PM, revealed she wanted the resident to return to this nursing facility after hospitalization. She stated the resident had been out to the Emergency Room on 11/23/15 due to resident's complaint of back pain. She stated the resident was given an injection of pain medication and sent back to the facility, early the morning of 11/24/15. The responsible party stated she went to the nursing facility around 2:00 PM and found the resident in bed, very drowsy, and incontinent of bladder. She stated when she talked to the nurse, she discovered the resident had not been out of bed, had not eaten anything (resident was a Diabetic) and was too drowsy to take any medications. She requested the resident to be sent back to the hospital. The facility later called and informed her the resident was a direct admit to a Psych Unit. She stated she did not receive a written notice of transfer on 11/24/15. She did receive a written notice of discharge on 11/30/15 stating the facility was discharging the resident because they could not meet the resident's medical needs.</p> <p>2. Review of Resident #11's medical record on 12/03/15 revealed the facility admitted Resident #11 on 08/25/15 with diagnoses including Unspecified Dementia with Behaviors, Paranoid Schizophrenia, Essential Hypertension, Insomnia, Muscle Weakness, Anxiety Disorder, Unspecified Psychosis, Osteopenia, and Difficulty Walking.</p> <p>Review of a Physician's Order, dated 09/07/15, revealed a transfer was required for Resident #11 to a nearby hospital for a psychiatric evaluation. Further review revealed Resident #11 was evaluated at the Emergency Department for a chief complaint of Changed Mental Status. The</p>	F 203			



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F 203	Continued From page 5 evaluation resulted in a diagnosis of Urinary Tract Infection (UTI). The resident was treated, received a prescription for antibiotics, and was transported back to the facility the same day.  Review of the physician orders, dated 09/08/15, revealed Resident #11's physician ordered for a transfer to a nearby hospital to evaluate the resident's wrist. Review of the hospital transfer forms, dated 09/08/15, revealed the resident was evaluated and diagnosed with a forearm fracture, of both, the radius and ulna. The Resident received a splint for immobilization, was treated for pain and received a prescription for pain medication. In addition, instructions for monitoring and follow up with an orthopedic on 09/10/15 was provided.  Continued record review revealed no documented evidence of a Transfer/Discharge Notice for Resident #11's transfers to either hospital on 09/07/15 or 09/08/15.  Interview, on 12/03/15 at 5:32 PM, with Licensed Practical Nurse (LPN) #1 revealed a Transfer/Discharge Notice was to be filled out as part of a resident's transfer procedure. A Transfer/Discharge Notice should be sent with the Emergency Medical Services (EMS) staff as part of assuring communication with the hospital for any resident that required a transfer. LPN #1 stated the procedure was to send a Transfer/Discharge Notice with any resident when transferred to another facility or hospital.	F 203		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR  Before a nursing facility transfers a resident to a	F 205		



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F 205	Continued From page 6 hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.  At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's admission packet information, it was determined the facility failed to provide written information regarding the facility's bed-hold policy and procedures for two (2) of fifteen (15) sampled residents that were transferred to a hospital. Resident #13 was not provided written information regarding the facility's bed-hold policy and given the opportunity to utilize those bed-hold days.  The findings include:  Interview with the Administrator, on 12/02/15 at 2:18 PM, revealed the facility was in the process of transitioning from one company to a new company. He stated there was no policy	F 205	F 205  1. Corrective action for the resident affected by the alleged deficient practice:  Resident #13 has returned to facility and a complete audit of resident chart was done by Medical Records personal and found bed hold policy was signed by responsible party upon admission.  2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:  Education on F 205 was done by regional nurse consultant and vice president of operations on 12-2-15. Implementation and education of bed hold procedure was done 12-3-15 in accordance with current corporate policy. In service with DON and SDC was held 12-3-15 with all licensed nursing staff on new bed hold policy and procedure. Inaccuracies will be addressed with immediate corrective actions and reeducation with correlating licensed nurse will follow.	12.25.15	

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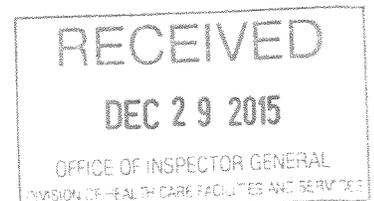
DEC 29 2015

OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

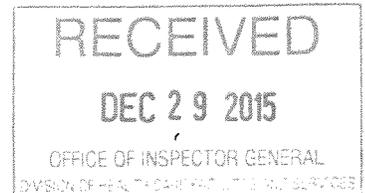
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F 205	<p>Continued From page 7 regarding bed-hold during the time of Resident #13's transfer to the hospital.</p> <p>Review of the admission packet information, given to all residents upon admission, revealed if a resident was not covered by Medicaid, or other payor source, and was temporarily hospitalized, the resident would agree to pay the facility at the prevailing daily rate in order to retain the resident's bed. The resident would be considered to be discharged and must move his/her personal belongings unless a bed-hold was arranged. If the resident was a Medicaid beneficiary, the facility would reserve the bed in accordance with applicable state law.</p> <p>In addition, a Resident Room Reservation Form was included in each admission packet. This form gave the resident three options regarding bed-hold. Option #1 was to request a bed-hold and pay the daily room rate. Option #2 was not to have a bed-hold. Option #3 was for Medicaid payor source and informed the resident they would have fourteen (14) days per calendar year for the bed-hold.</p> <p>Review of the closed clinical record for Resident #13 revealed the facility admitted the resident on 02/27/15 with diagnoses of End Stage Renal Disease with Dependence on Dialysis, Diastolic Heart Failure, Bi-Polar Disorder, Anxiety, Tremors, and Chronic Pain.</p> <p>Review of the most current Minimum Data Set (MDS) assessment, dated 10/31/15, revealed the facility conducted a Brief Interview for Mental Status (BIMS) test for Resident #13 with a score of fifteen (15) out of possible fifteen (15), meaning the resident was cognitively intact.</p>	F 205	<p>3. Measures/Systematic changes put in place to assure the alleged deficient practice does not re occur:</p> <p>A chart review of all residents discharged or transferred will be conducted Monday-Friday during morning stand-up meeting by IDT to ensure appropriate discharge, transfer and bed hold policy was completed correctly and was given at time of transfer and documented. Social Services Director will do a follow up call with responsible party to explain bed hold policy and mail one out to be signed by responsible party. Any inaccuracies will be reported to administrator or DON and corrective actions will be taken.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not occur:</p> <p>A chart review of all residents discharged or transferred will be conducted Monday-Friday during morning stand-up meeting by IDT to ensure appropriate discharge, transfer and bed hold policy was</p>	



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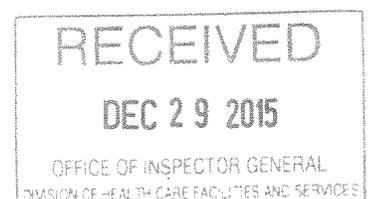
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F 205	Continued From page 8  Interview with the Social Service Worker, on 12/02/15 at 10:58 AM, revealed the facility did not issue written information regarding bed-hold. She stated the facility staff would normally call the family and asked them if they wanted to hold the bed and what the cost would be. She stated she had not spoken with the family regarding Resident #13.  Interview with the Admission Coordinator, on 12/02/15 at 11:10 AM, revealed she had called and explained to Resident #13's responsible party they would have to pay to keep the resident's bed. She stated she was told since the resident went to a Psych Hospital the Medicaid bed-hold did not apply. She stated she never provided written information regarding the resident's bed-hold options, she would only call them. She stated to her knowledge there was no policy for bed-hold options, only the information provided in the admission packet. She stated when she called Resident #13's responsible party, they chose not to pay the bed-hold; therefore, the resident was discharged from the facility and another resident was admitted to the bed. She stated she had placed the resident on the waiting list for the next available bed.  Interview with the Administrator, on 12/2/15 at 2:18 PM, revealed there was no policy regarding bed-hold. He stated he was under the impression that if a resident was sent to a Psych Hospital, Medicaid would not pay for a bed-hold. He stated he was looking at facility to facility transfer and didn't think the facility could bill for that. He stated a bed-hold was offered via phone, but the family refused. Therefore, the resident was discharged	F 205	completed correctly and was given at time of transfer and documented. IDT will report all findings to QAPI committee and recommendations will be made as needed.	



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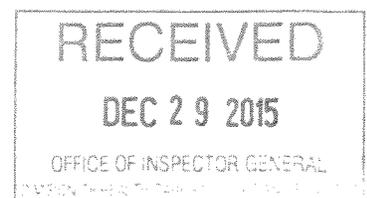
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F 205	Continued From page 9 as of 11/24/15.  Interview with Resident #13's responsible party, on 12/03/12 at 2:24 PM, revealed she was told since the resident went to a Psych Hospital, Medicaid would not pay for a bed-hold and if she wanted to hold the resident's bed, she would have to pay the daily room rate (\$216.00). She stated she could not afford to pay that amount and the facility told her the resident would be discharged. She received a discharge notice on 11/30/15. She stated she wanted the resident to return to the facility and had been very worried about where to place the resident after hospitalization.  Interview with the Business Office Manager, on 12/03/15 at 9:30 AM, revealed Resident #13 was a Medicaid beneficiary with five (5) qualifying days left this year for bed-hold. She stated the resident should have been able to utilize the bed-hold days with this hospitalization.  A post survey telephone interview with the Central Office Supervisor for the Department of Community Based Services, on 12/04/15 at 8:00 AM, revealed she had checked with the Medicaid Central Office and was told any resident who was a Medicaid Beneficiary in a Long Term Care Facility would receive fourteen (14) bed-hold days per year. These bed-hold days would apply to Psych and Acute Hospitalizations.	F 205			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279			



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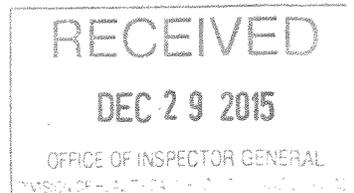
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F 279	Continued From page 10  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on interviews and closed record review, it was determined the facility failed to develop a care plan to address behaviors for one (1) of fifteen (15) sampled residents. Resident #13 started exhibiting behaviors of yelling at staff, refusal of medications and dialysis treatments, and paranoia. The facility failed to develop a care plan with specific interventions to address those behaviors. The resident's refusal for dialysis resulted in two hospitalizations.  The findings include:  Interview with the Director of Nursing (DON), on 12/03/15 at 10:05 AM, revealed the facility utilized the Resident Assessment Instrument (RAI) for their care plan policy.	F 279	F 279  1. Corrective action for the resident affected by the alleged deficient practice  Resident #13 care plan has been reviewed and revised to ensure the care plan continues to accurately reflect the resident's status and appropriate interventions for behaviors.  2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:  Care plans of all residents (62) were reviewed by IDT, Regional Nursing consultant and Regional Vice President of Operations 12.3.15-12.4.15. All residents found to have behaviors were given a behavior care plan with appropriate interventions for their specific behavior. Behaviors and interventions will be monitored for appropriateness of interventions. Education was done with IDT 12.4.15 by corporate consultants on updating care plans, developing care plans and interim plan of care as per policy.	12.25.15	



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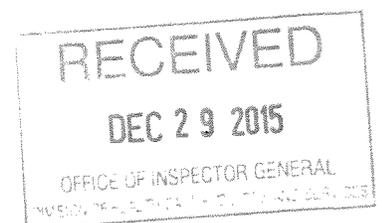
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F 279	<p>Continued From page 11</p> <p>Review of the RAI manual, Chapter 4, page 4-8, Care planning, revealed the comprehensive care plan was an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The overall care plan should be oriented towards preventing avoidable declines in functioning or functional level or otherwise clarifying why another goal takes precedence (palliative approaches in end of life situations); managing risk factors to the extent possible or indicating the limits of such interventions; addressing ways to try to preserve and build upon resident strengths; evaluating treatment or measurable objectives; timetables and outcomes of care; and addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.</p> <p>Review of the closed clinical record for Resident #13 revealed the facility admitted the resident on 02/27/15. Review of the most current diagnoses included End Stage Renal Disease with dialysis, Congestive Heart Failure, Bi-Polar Disorder, Hypothyroidism, Pain, Anxiety Disorder, and Essential Tremors.</p> <p>Review of the comprehensive care plan, dated 03/12/15, revealed the resident went out to dialysis three (3) times a week. Review of a care plan conference, dated 10/14/15, revealed documentation the resident refused treatment and dialysis at times and experienced episodes of agitation. However, there was no care plan developed to address those behaviors.</p> <p>Review of the most recent Minimum Data Set (MDS) quarterly assessment, dated 10/31/15,</p>	F 279	<p>3. Measures/Systematic changes put in place to assure the alleged deficient practice does not re occur:</p> <p>Implementation and education of corporate policy and procedure on care planning was done 12.4.15 by corporate consultants with IDT. SDC educated nursing staff on documentation and monitoring of resident behaviors on 12.7.15. All PRN staff will be educated before date of compliance.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not occur:</p> <p>Care Plans will be reviewed by IDT for accuracy and appropriateness of interventions for the associated behaviors with resident's quarterly MDS assessments. All issues will be brought to monthly QA committee for review/interventions.</p>		



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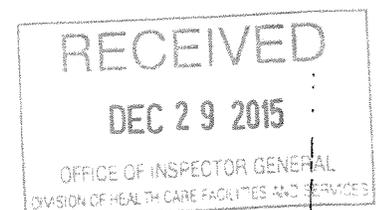
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F 279	<p>Continued From page 12</p> <p>revealed the facility conducted a Brief Interview for Mental Status (BIMS) exam with a score of fifteen (15) out of possible fifteen (15) meaning the resident was cognitively intact. The facility assessed the resident to require assistance from staff for most Activities of Daily Living (ADL).</p> <p>Continued review of the resident's closed clinical record revealed the resident was admitted to an acute hospital from 08/02/15 to 08/07/15 for shortness of air. Review of the hospital History and Physical, dated 08/02/15, revealed the resident had missed his/her dialysis prior to the hospitalization. The hospital discharge summary, dated 08/17/15, revealed the resident experienced Congestive Heart Failure with volume overload and had to be dialyzed.</p> <p>Review of the readmission physician orders, dated 08/07/15, revealed an order for hemodialysis three times a week, Monday, Wednesday, and Friday and the physician had placed the resident on fluid restriction of 1500 milliliters (ml) per day. Review of a SBAR Communication Form, dated 11/14/15 at 2:54 PM, revealed the resident had been transferred to the local hospital's Emergency Department (ED) for a change in condition. The nurse documented the resident was non-responsive, arms flaccid, blood pressure elevated and the resident was incontinent of bladder, which was new for this resident. The nurse's documented the resident had a decreased consciousness and new or worsening behavioral symptoms. Review of the section for other relevant information, the nurse documented the resident had missed a dialysis treatment. The form stated the resident had been to the local ED on 11/13/15 for pain and had received a pain medication</p>	F 279			



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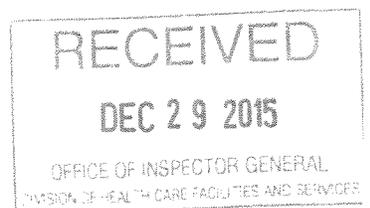
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F 279	Continued From page 13 injection and returned to the nursing facility. On 11/14/15, the resident was transported to the local ED and then transported to another hospital for emergent dialysis and admitted for treatment. Review of the hospital's discharge summary, dated 11/17/15, revealed the resident had not received dialysis for over five (5) days. The physician stated the resident was in Pulmonary Edema, Diastolic Congestive Heart Failure-converted to volume overload from missed hemodialysis, Hyperkalemia due to missed hemodialysis, and Altered Mental Status related to possibly uremia and combination of psychotropic medications while not getting dialysis. The physician documented the resident's symptoms immediately improved after dialysis. The physician documented he had strongly urged the resident not to miss dialysis again. However, there was no documentation in the clinical record at the nursing facility regarding the resident's refusal of dialysis and what interventions the facility attempted.  Review of the Dialysis Center progress note, dated 11/23/15 at 12:28 PM, revealed the resident complained of pain and Tylenol 500 mg was given. In addition, the nurse documented the resident was upset and was happy one minute and angry the next. A note from the Social Worker at the Dialysis Center stated the resident was belligerent with mania present. The center contacted the resident's family member and she requested a Psych evaluation. The resident was transported back to the Nursing Facility after the dialysis treatment. At 4:45 PM, the facility transported the resident to the hospital for evaluation of behaviors. The resident was returned to the Nursing Facility on 11/24/15 at 2:04 PM, with the nurse at the hospital stating	F 279		



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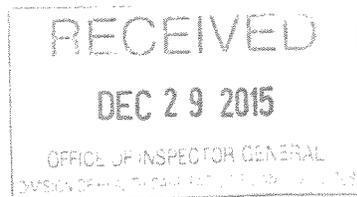
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F 279	<p>Continued From page 14</p> <p>there wasn't anything wrong with the resident. The resident was not exhibiting any behaviors at that time. Later that day, the resident was sent back to the hospital for direct admit to the Psych Unit for evaluation of medications and increased behaviors. However, no care plan was developed to address those behaviors.</p> <p>Interview with a family member, on 12/03/15 at 2:24 PM, revealed the resident would refuse dialysis occasionally, but she could get the resident to dialysis if the facility called. She stated about three (3) weeks ago, the resident was sent to the ED related to pain. The resident was sent back after a pain medication injection. She stated the resident had missed dialysis that day (Friday-November 13 th). She stated the ED physician was aware of the missed dialysis treatment, but wanted the facility to monitor the resident closely. She stated the resident was returned to the facility early in the morning around 2:00 AM. She stated she went home to get some rest and returned to the Nursing Facility around 2:00 PM that day. She stated she found the resident laying in bed wet and unresponsive. She stated she spoke with the nurse and found the resident had not eaten breakfast or lunch, and was too drowsy to take the medications scheduled at 7:00 AM and 12:00 Noon. She requested the resident be transported back to the ED. The resident was transported to the local ED and then transported to another hospital for emergency dialysis treatment. She stated recently the resident had been to the ED several times for pain. She stated they could not get the resident's pain in control and the pain medication injection he/she had received at the ED the night before made the resident too drowsy. She validated the resident would refuse dialysis treatment</p>	F 279			



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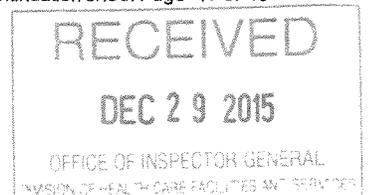
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F 279	<p>Continued From page 15</p> <p>occasionally and she would come and take the resident in her own personal car. However, the facility did not request her assistance on 11/13/15 and the resident ended up in the ED and had to be emergent dialyzed.</p> <p>Interview with Licensed Practice Nurse (LPN) #1, on 12/03/15 at 2:20 PM, revealed the resident was usually okay unless he/she didn't receive their medications exactly at the scheduled time. The resident refused medications telling staff they were poison and he/she had a chip in his/her brain and if the resident didn't get his/her medications at 7:00 AM, 12:00 Noon, 4:00 PM, and 7:00 PM exactly, the resident would say their brain would short circuit. LPN #1 stated the resident would refuse dialysis at times, even though the resident knew it would harm him/her. She stated the behaviors should have been documented in the medical record.</p> <p>Interview with the Social Worker and the MDS Coordinator, on 12/13/15 at 4:23 PM, revealed the Social Worker was responsible for completing the section of the MDS regarding behaviors and nursing was responsible for the monitoring of Psychotropic medications and the effectiveness. The Social Worker stated the resident was exhibiting behaviors such as yelling at staff during care, but did not know the resident was refusing medications. She stated she would look under the Caretracker and nursing would report any behaviors to her. She stated she was aware the resident had refused dialysis but failed to develop a care plan to address the problem. She stated this would be the type of behavior that required a care plan with interventions. The MDS Coordinator stated she or the Director of Nursing would conduct the care plan conference. She was</p>	F 279			



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F 279	Continued From page 16 aware of Resident #13's refusal of medication and dialysis treatment; however, she had not reviewed the resident's care plan for completion and didn't realize the behaviors had not been care planned.	F 279			
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 observation, interview, record review and policy review, it was determined the facility failed to revise the care plan for two (2) of fifteen (15) sampled residents, (Residents #1 and #15). The facility failed to revise the care plan to	F 280	F 280  1. Corrective action for the resident affected by the alleged deficient practice:  The care plan for resident #1 and #15 has been reviewed to ensure the plan of care continues to accurately reflect the resident's current status and behaviors. Resident #15 no longer believes she is paralyzed. Resident #1 has a behavior care plan to address the current behaviors.  2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:  Care plans of all residents (62) were reviewed by IDT, Regional Nursing consultant and Regional Vice President of Operations 12.3.15-12.4.15. All residents found to have behaviors were given a	12.25.15	



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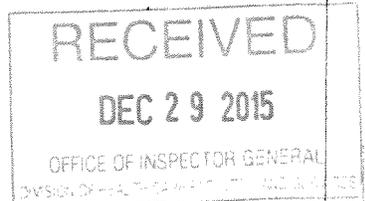
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT COLONIAL REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004		
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F 280	<p>Continued From page 17</p> <p>address Resident #15's behaviors of thinking they were paralyzed and Resident #1's yelling out for help.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 10:05 AM, revealed the facility followed the Resident Assessment Instrument (RAI) as the care plan policy.</p> <p>Review of the RAI Minimum Data Set (MDS) 3.0 Section 4, 4.6, page 4-12, #15, revealed the effectiveness of the care plan must be evaluated from its Initiation and modified as necessary. Changes to the care plan should occur as needed in accordance with professional standards or practice and documentation. The overall care plans should be oriented towards: preventing avoidable declines in functioning and addressing ways to try to preserve and build upon resident strengths.</p> <p>1. Review of Resident #15's clinical record revealed the facility admitted the resident on 04/21/14 with diagnoses of Dementia with Behavioral Disturbance, Difficulty Walking, Morbid Obesity, Immobility Syndrome, Major Depressive Disorder and Anxiety.</p> <p>Review of Resident #15's Minimum Data Set (MDS) Annual Assessment, dated 10/02/15, revealed the facility assessed Resident #15 utilizing a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) which meant the resident was cognitively intact and interviewable.</p> <p>Review of Resident #15's Behavior Care Plan, dated 02/07/14, revealed Resident #15 had</p>	F 280	<p>behavior care plan with appropriate interventions for their specific behavior. Behaviors and interventions will be monitored for appropriateness of interventions. Education was done with IDT 12.4.15 by corporate consultants on updating care plans, developing care plans and interim plan of care as per policy.</p> <p>3. Measures/Systematic changes put in place to assure the alleged deficient practice does not re occur:</p> <p>Implementation and education of corporate policy and procedure on care planning was done 12.4.15 by corporate consultants with IDT. SDC educated nursing staff on documentation and monitoring of resident behaviors on 12.10.15. All PRN staff will be educated before date of compliance.</p>		

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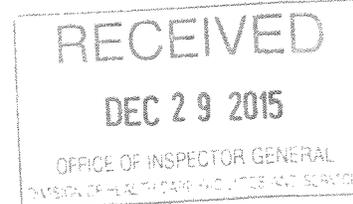
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F 280	<p>Continued From page 18</p> <p>episodes of being verbally abusive towards staff as evidence by him/her yelling/cursing at staff and rejecting care. There were no interventions listed on the care plan to address these behaviors or direct staff in how to approach these behaviors of feeling paralyzed.</p> <p>Observation of Resident #15, on 12/02/15 at 4:25 PM, on 12/03/15 at 8:10 AM, and on 12/03/15 at 12:00 PM, revealed Resident #15 was either up or resting resting in bed with no behaviors displayed.</p> <p>Review of Resident #15's Psychiatric Follow-up Evaluations, dated 05/28/15, 06/29/15, 07/23/15, revealed per staff Resident #15 believed he/she was paralyzed and required staff to do everything for him/her.</p> <p>Review of Resident #15's Resident Behavior by day Chart, revealed Resident #15 was monitored for wandering, verbal behavior, physical behavior, socially inappropriate and rejection of care.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 12/03/15 at 1:00 PM, revealed Resident #15 would refuse showers, but really did not have any behaviors.</p> <p>Interview with CNA #2, on 12/03/15 at 1:30 PM, revealed Resident #15 liked to refuse showers and would say staff was mean and then would take his/her shower. There were no other behaviors by the resident.</p> <p>Interview with the Social Services Director, on 12/03/15 at 4:35 PM, revealed Resident #15 had verbal behaviors and refused care. The Social Services Director stated she did not know how</p>	F 280	<p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not occur:</p> <p>Care Plans will be reviewed with the quarterly MDS assessments by IDT for accuracy and appropriateness of interventions for the associated behaviors. All issues will be brought to monthly QA committee for review/interventions.</p>	



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F 280	<p>Continued From page 19</p> <p>long it had been since Resident #15 had those type of behaviors.</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 3:41 PM, revealed she had not noticed any behaviors. No yelling or cussing as well. The DON stated Resident #15's care plan probably needed to be revised. The DON stated she attended the care plan meetings on Wednesdays and would go over issues and make revisions as needed. The DON stated she had not asked about the accuracy of the care plans and the need for revision.</p> <p>2. Review of Resident #1's clinical record revealed the facility admitted the resident on 05/21/13 with diagnoses of Alzheimer's Disease, Dementia with Behavior, Anxiety, Major Depressive Disorder and Chronic Pain. Review of Resident #1's MDS Annual Assessment, dated 11/18/15, revealed the facility assessed Resident #1 with a BIMS and score the resident as a 99 which meant the resident could not complete the interview and would not be interviewable.</p> <p>Observation of Resident #1, on 12/01/15 at 11:20 PM, 12:05 PM, 1:20 PM and 3:45 PM, on 12/02/15 at 8:10 AM, 8:45 AM, 9:42 AM, 2:15 PM and 4:15 PM, and on 12/03/15 at 8:10 AM, revealed the resident displayed no behaviors.</p> <p>Interview with CNA #1, on 12/03/15 at 1:00 PM, revealed Resident #1 had some behaviors like wanting to lay down in bed or screaming out that he/she wanted to get back up.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/03/15 at 1:44 PM, revealed Resident #1</p>	F 280			



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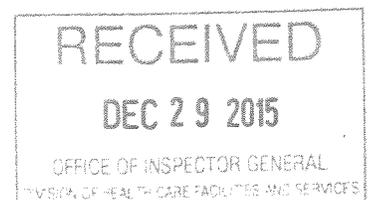
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F 280	<p>Continued From page 20</p> <p>had behaviors such as yelling out for help. Resident #1 would yell out to either voice he/she was in pain or needed to go to the bathroom.</p> <p>Review of Resident #1's Behavior Care Plan, dated 02/07/14, revealed Resident #1 would continuously yell out and continuously yell out for help when the resident needed to go to the bathroom or was in pain. But no specific interventions were listed regarding the resident needing to go to the bathroom, or if the resident was in pain or needed to go to bed.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 12/03/15 at 4:22 PM, revealed she had not revised the behavior care plan. She stated she did attend the care plan meeting on Wednesday and reviewed the care plans. She and the DON were responsible for the accuracy/revision of the care plans.</p> <p>Interview with the Social Services Director, on 12/03/15 at 4:35 PM, revealed the care plans could be more individualized. The Social Services Director also stated she had not reviewed the behavior sheets and had not attended care plan meetings in while to revise any care plans.</p> <p>Interview with the DON, on 12/03/15 at 3:41 PM, revealed Resident #1's care plan could have been revised to have more personalized interventions such as to check on the resident to see if they were in pain, hungry or needed to be with other residents or staff.</p> <p>Interview with the Administrator, on 12/03/15 at 2:47 PM, revealed Resident #1 liked to get up out of bed and would sometimes cry at night because he/she had pain. The Administrator stated that</p>	F 280		

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F 280	Continued From page 21 the care plan should be revised to be more personalized, as Resident #1's care plan was too vague.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to implement the care plan for one (1) of fifteen (15) sampled residents, (Resident #1). The facility staff failed to place geri-sleeves on Resident #1 as care planned.  The findings include:  Interview with the Director of Nursing (DON), on 12/03/15 at 10:05 AM, revealed the facility followed the Resident Assessment Instrument (RAI) as it related to care plans.  Review of the RAI Minimum Data Set (MDS) 3.0 Section 4, 4.6, page 4-11, #12, revealed the Inter-Disciplinary Team (IDT) identified specific, individualized steps or approaches that would be taken to help the resident achieve his or her goals. The approaches served as instructions for resident care and provide for the continuity of care by all staff. Precise and concise instructions help staff understand and implement interventions.	F 282	F 282  1. Corrective action for the resident affected by the alleged deficient practice:  Resident #1 was monitored by nursing staff for placement of Geri-sleeves. Skin assessment was done with no new significant change noted due to the alleged deficient practice.  2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:  Care plans were reviewed for all residents with protective devices and no residents were found to be affected by the alleged deficient practice.  3. Measures/Systematic changes put in place to assure the alleged deficient practice does not re occur:  Education was done by SDC and DON with nursing staff on the procedure of reviewing care plans daily and following the care plans. Audit of care plans will be	12.25.15	



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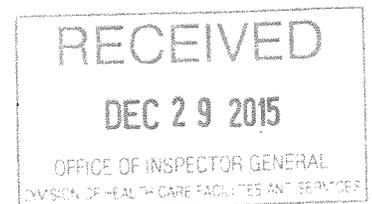
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F 282	<p>Continued From page 22</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 05/21/13, with diagnosis of Alzheimer's Disease, Left Knee Contracture, Difficulty in Walking, Muscle Weakness and Chronic Pain.</p> <p>Review of Resident #1's Minimum Data Set (MDS) Annual Assessment, dated 11/18/15, revealed the facility assessed Resident #1 utilizing a Brief Interview for Mental Status (BIMS) with a score of 99 which meant the resident was not able to complete the interview task.</p> <p>Review of Resident #1's Activity of Daily Living (ADL) care plan, dated 04/15/15, revealed the staff was to place geri sleeves to the bilateral arms of Resident #1.</p> <p>Review of Resident #1's Certified Nursing Assistants (CNA) care plan, not dated, revealed the CNAs were to place geri sleeves on Resident #1's bilateral arms.</p> <p>Observation of Resident #1 arms, on 12/01/15 at 12:05 PM, revealed Resident #1 was not wearing geri sleeves on either arm and his/her arms had bruises.</p> <p>Further observation of Resident #1, on 12/01/15 at 1:20 PM and 3:45 PM, revealed Resident #1 was not wearing any geri sleeves.</p> <p>Observation of Resident #1, on 12/02/15 at 8:45 AM, revealed Resident #1 was sitting in his/her wheelchair with no geri sleeves on his/her arms.</p> <p>Interview with CNA #1, on 12/03/15 at 1:00 PM, revealed she was not aware Resident #1 was to</p>	F 282	<p>done by DON/SDC/unit managers weekly for 4 weeks and then monthly X2 months.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not occur:</p> <p>DON/SDC/unit managers will audit TAR and observe resident for accuracy of placement of Geri-sleeve weekly X4 weeks and then monthly X2 months. Any issues will be brought to the attention of the DON/ Unit managers and appropriate interventions will be implemented immediately. Further issues will be brought to the QA committee by the DON for further review.</p>		

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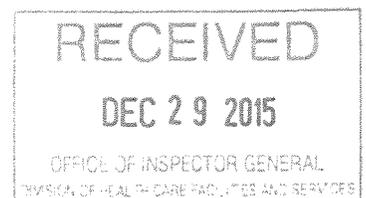
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F 282	Continued From page 23 wear geri sleeves. CNA #1 stated she was supposed to review her CNA plan daily and had not. She stated if she had checked that Resident #1 did not have on his/her geri sleeves, she would have informed the nurse to help her look for them.  Interview with Licensed Practical Nurse (LPN) #1, on 12/03/15 at 1:44 PM, revealed the nursing staff was suppose to ensure the CNA's were providing care as care planned  Interview with the Minimum Data Set (MDS) Coordinator, on 12/03/15 at 4:22 PM, revealed the nursing staff was to follow the care plans on a daily basis.  Interview with the Director of Nursing (DON), on 12/03/15 at 3:41 PM, revealed the geri sleeves were used to prevent injury to the resident's arm. The DON stated it was important for the care plan to be followed because it was the plan of care for the resident.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced	F 309		



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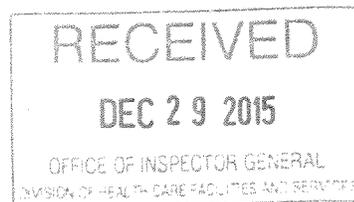
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F 309	Continued From page 24 by: Based on observation, interview, record review and policy review, it was determined the facility failed to follow physician orders for two (2) of fifteen (15) sampled residents, (Residents #1 and #13). The facility staff failed to apply geri sleeves to Resident #1 as ordered by the physician. Resident #13 was to receive dialysis three (3) times a week and although Resident #13 would refuse; there was no evidence the facility took any action to get the resident the ordered dialysis.  The findings include:  Interview with the Director of Nursing (DON), on 12/03/15 at 10:05 AM, revealed there was no policy for following physician orders. There was no policy for assistive devices as well.  1. Review of Resident #1's clinical record revealed the facility admitted the resident on 05/21/13 with diagnoses of Alzheimer's Disease, Left Knee Contracture, Difficulty in Walking, Muscle Weakness and Chronic Pain.  Review of Resident #1's Minimum Data Set (MDS) Annual Assessment, dated 11/18/15, revealed the facility assessed Resident #1 utilizing the Brief Interview for Mental Status (BIMS) with a score of 99 meaning the resident could not complete the interview task and was not interviewable.  Review of Resident #1's Physician Orders, dated 10/01/13 through 10/31/15, revealed the physician ordered the staff to place geri sleeves to Resident #1's bilateral arms.  Observation of Resident #1's arms, on 12/01/15	F 309	F 309  1. Corrective action for the resident affected by the alleged deficient practice:  Resident #1 was monitored by nursing staff for placement of Geri-sleeves. Skin assessment was done with no new significant change noted due to the alleged deficient practice. Resident #13 has returned to the facility with no complications from the apparent deficient practice.  2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:  Care plans were reviewed for all residents with Geri-sleeve orders and no residents were found to be negatively affected by the alleged deficient practice. Resident #13 is the only resident with a care plan for dialysis. Interventions have	12.25.15



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F 309	<p>Continued From page 25</p> <p>at 12:05 PM, revealed the resident was wearing a short sleeve shirt with no gerl sleeves on either arm and the resident's arms had bruises.</p> <p>Further observation of Resident #1, on 12/01/15 at 1:20 PM and 3:45 PM, revealed Resident #1 was not wearing any gerl sleeves.</p> <p>Observation of Resident #1, on 12/02/15 at 8:45 AM, revealed Resident #1 was observed sitting in his/her wheelchair. Resident #1 had a short sleeve shlrt on with no gerl sleeves on his/her arms. Both arms were observed to have red and blue bruises.</p> <p>Further observation of Resident #1, on 12/02/15 at 9:42 AM, 2:15 PM and 4:15 PM, revealed Resident #1 did not have his/her gerl sleeves on.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 12/03/15 at 1:00 PM, revealed she was not aware Resident #1 was to wear gerl-sleeves. CNA #1 stated she was suppose to review her CNA plan every shift. CNA #1 stated the gerl sleeves were used to prevent bruising and scratching to Resident #1's arms. CNA #1 stated she worked with Resident #1 on 12/02/15 as Resident #1's aid.</p> <p>Interview with the Licensed Practical Nurse (LPN) #1, on 12/03/15 at 1:44 PM, revealed staff were to follow the physicians orders and the nursing staff was responsible to ensure the CNA's provided the care ordered.</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 1:35 PM, revealed she expected the CNA staff to review their CNA care plans when they come on the shift and as needed. The DON</p>	F 309	<p>been put into place to address possible refusals of dialysis for resident #13.</p> <p>3. Measures/Systematic changes put in place to assure the alleged deficient practice does not re occur:</p> <p>Implementation and education of corporate policy and procedure on care planning was done 12.4.15 by corporate consultants with IDT. Education was done by DON and SDC on resident refusal of care plan and appropriate interventions for the residents if a refusal of care occurs. MD orders will be audited Monday-Friday during morning stand-up meeting with updates to resident care plans done if needed.</p>



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F 309	<p>Continued From page 26</p> <p>stated the geri sleeves were ordered because Resident #1 pcked at his/her arms. The DON stated she expected the staff to follow the physician orders.</p> <p>2. Review of the closed clinical record for Resident #13 revealed the facility admitted the resident on 02/27/15. Review of the most current diagnoses included End Stage Renal Disease with dialysis, Congestive Heart Failure, Bi-Polar Disorder, Hypothyroidism, Pain, Anxiety Disorder, and Essential Tremors.</p> <p>Review of the most recent Minimum Data Set (MDS) quarterly assessment, dated 10/31/15, revealed the facility conducted a Brief Interview for Mental Status (BIMS) exam with a score of fifteen (15) out of possible fifteen (15) which meant Resident #13 was cognitively intact and interviewable. The facility assessed the resident to require assistance from staff for most Activities of Daily Living (ADL).</p> <p>Review of the comprehensive care plan, dated 03/12/15, revealed the resident went out to dialysis three (3) times a week. Review of a care plan conference, dated 10/14/15, revealed documentation the resident refused treatment and dialysis at times and experienced episodes of agitation.</p> <p>Continued review of the resident's clinical record revealed the resident was admitted to an acute hospital from 08/02/15 to 08/07/15 for shortness of air. The hospital discharge summary, dated 08/07/15, revealed the resident experienced Congestive Heart Failure with volume overload and had to be dialyzed. Review of the hospital</p>	F 309	<p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not occur:</p> <p>IDT will review all charts on residents who refuse care Monday-Friday during morning stand-up meeting to assure appropriate interventions were used for associated behavior. An audit of behavior charting will be done by Social Services Coordinator Monday-Friday before morning stand up meeting. All incidents will be reported to DON for further investigation. TARs will be audited monthly for accuracy of protective covering placement at the beginning of each month x 3 months. All issues will be brought to the attention of IDT for appropriate interventions. DON will bring all systematic issues to monthly QA meeting for review.</p>	
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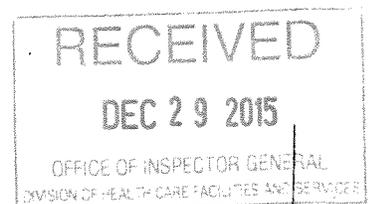
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT COLONIAL REHAB & WELLNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004		
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F 309	<p>Continued From page 27</p> <p>History and Physical, dated 08/02/15, revealed the resident had missed his/her dialysis prior to the hospitalization. Review of the readmission physician orders, dated 08/07/15, revealed an order for hemodialysis three times a week, Monday, Wednesday, and Friday and the physician had placed the resident on fluid restriction of 1500 milliliters (ml) per day.</p> <p>Review of a Nurse's Note, dated 11/10/15 at 8:11 AM, revealed the nurse received a physician order to transfer the resident to the local acute hospital. At 10:10 AM, the nurse documented she had received report from the acute hospital stating the resident diagnostic test revealed arthritis and kidney stones. The resident had been given Morphine pain medication and returned to the nursing facility.</p> <p>Review of a Situation, Background, Assessment, Recommendation (SBAR) Communication Form, dated 11/14/15 at 2:54 PM, revealed the resident had been transferred to the local hospital's Emergency Department (ED) for a change in condition. The nurse documented the resident was non-responsive, arms flaccid, blood pressure elevated and the resident was incontinent of bladder, which was new for this resident. The nurse's documented the resident had a decreased consciousness and new or worsening behavioral systems.</p> <p>Review of the section for other relevant information, the nurse documented the resident had missed a dialysis treatment. The form revealed the resident had been to the local ED on 11/13/15 for pain and had received a pain medication injection and return to the nursing facility. On 11/14/15, the resident was transported</p>	F 309		

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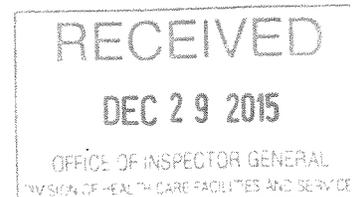
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F 309	<p>Continued From page 28</p> <p>to the local ED and then transported to another hospital for emergent dialysis and admitted for treatment.</p> <p>Review of the hospital's discharge summary, dated 11/17/15, revealed the resident had not received dialysis for over five (5) days. The physician stated the resident was in Pulmonary Edema, Diastolic Congestive Heart Failure-converted to volume overload from missed hemodialysis, Hyperkalemia due to missed hemodialysis, and Altered Mental Status related to possibly uremia and combination of psychotropic medications while not getting dialysis. The physician documented the resident symptoms immediately improved after dialysis. The physician documented he had strongly urged the resident not to miss dialysis again. However, there was no evidence the facility took action to ensure the resident continued with dialysis.</p> <p>Interview with a family member, on 12/03/15 at 2:24 PM, revealed although the resident was cognitively intact, she had provided oversight with decision making for the resident at the resident's personal home and at the Nursing Facility and knew the resident's needs.</p> <p>She stated the resident had lived alone for over seven (7) years and had refused dialysis rarely. She stated since admission to the Nursing Facility, the resident may have refused dialysis occasionally, but she could get the resident to dialysis if the facility called.</p> <p>She stated about three (3) weeks ago, the resident was sent to the ED related to pain. The resident was sent back after a pain medication injection. She stated the resident had missed</p>	F 309			



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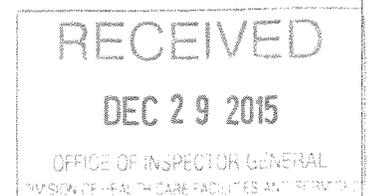
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F 309	<p>Continued From page 29</p> <p>dialysis that day (Friday-November 13th). She stated the ED physician was aware of the missed dialysis treatment, but wanted the facility to monitor the resident closely. She stated the resident was returned to the facility early in the morning around 2:00 AM.</p> <p>She stated she went home to get some rest and returned to the Nursing Facility around 2:00 PM that day. She stated she found the resident laying in bed wet and unresponsive. She stated she spoke with the nurse and found the resident had not eaten breakfast or lunch, and was too drowsy to take the medications scheduled at 7:00 AM and 12:00 Noon. She stated the resident had not had any food or water since his/her return from the ED.</p> <p>She requested the resident be transported back to the ED. The resident was transported to the local ED and then transported to another hospital for emergency dialysis treatment. She stated recently the resident had been to the ED several times for pain. She stated they could not get the resident's pain in control and the pain medication injection he/she had received at the ED the night before made the resident too drowsy.</p> <p>She validated the resident would refuse dialysis treatment occasionally and she would come and take the resident in her own personal car. However, the facility did not request her assistance on 11/13/15 and the resident ended up in the ED and had to be emergent dialyzed.</p> <p>Interview with Licensed Practice Nurse (LPN) #1, on 12/03/15 at 2:20 PM and 4:33 PM, revealed the resident's refusal should have been documented in the medical record. However,</p>	F 309		



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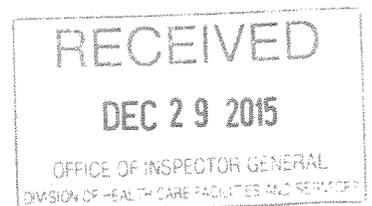
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F 309	Continued From page 30 review of the electronic and hard copy record revealed the resident's behaviors of refusal of medications and dialysis was not found.  Interview with the Social Worker and the MDS Coordinator, on 12/13/15 at 4:23 PM, revealed she was aware the resident had refused dialysis, but failed to develop a care plan to address the problem. She was aware of Resident #13's refusal of medication and dialysis treatment; however, she had not reviewed the resident's care plan for completion and didn't realize the behaviors had not been addressed.	F 309			
F 329 SS=D	483.25(l) 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.	F 329	F 329  1. Corrective action for the resident affected by the alleged deficient practice:  A chart audit was done for residents #1 and #15. GDR was performed for resident #1 on 12.18.15. GDR was	12.25.15	



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F 329	Continued From page 31  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure residents were free from Unnecessary Medications for two (2) of nine (9) sampled residents on psychotropic medications, (Residents #1 and #15). The facility failed to complete Gradual Dose Reductions and justification for continuing the use of drugs through behavior monitoring for Resident #1 and #15.  The findings include:  Review of the facility's policy regarding Use of Psychotropic Medication including Anti-psychotics in the elderly, not dated, revealed to ensure the use of psychotropic medications were utilized in accordance with and based on clinical standards and manufacturers guidelines and/or had clinically relevant and pertinent rationales documented to identify the specific signs and symptoms and why the benefit of the medication outweighs the risk of its use. Residents who use antipsychotic drugs would receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue the drugs. Residents who received any psychotropic medications would be monitored to ensure the resident had a medical condition warranting the use, that the drug was used at the least effective dose and side effects were minimized as possible.	F 329	performed for resident #15 on 12.9.15. Resident will be monitored for success of GDR.  2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:  A chart audit was performed on all residents on psychotropic medication to assure appropriate drug regimen, appropriate dose of drugs and necessary drugs are being administered to all residents receiving psychotropic medication. For residents found to be at higher risk of possible adverse consequences, GDRs were conducted and residents will be monitored for successfulness of GDR.  3. Measures/Systematic changes put in place to assure the alleged deficient practice does not re occur:  Implementation and education of Psychiatric drug monitoring procedure per corporate policy was implemented 12.4.15 and educated on by corporate consultants. This procedure included but was not limited to documentation of behaviors, non-psychotropic interventions and scheduled reviews of	



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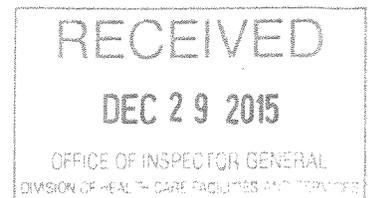
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F 329	<p>Continued From page 32</p> <p>1. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 04/21/14 with diagnosis of Dementia with Behavioral Disturbance, Difficulty Walking, Morbid Obesity, Immobility Syndrome, Major Depressive Disorder and Anxiety.</p> <p>Review of Resident #15's Minimum Data Set (MDS) Annual Assessment, dated 10/02/15, revealed the facility assessed Resident #15 utilizing a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) which meant Resident #15 was cognitively intact and interviewable.</p> <p>Review of Resident #15's care plan, dated 02/07/14, revealed the facility care planned the resident for episodes of verbal abuse, yelling and cursing at staff with rejection of care.</p> <p>Further record review of Resident #15's Physician Orders, dated 12/01/15 through 12/31/15, revealed Resident #15 was prescribed Zoloft 100 mg daily (used for mood and ordered on 03/30/15), Wellbutrin XL before breakfast (used for Depression and ordered on 04/22/14), Aricept 10 mg daily (used for Memory and ordered on 04/22/14), Zyprexa 15 mg at bedtime (used for Delusional Disorder and ordered on 04/27/14), and Xanax 1 mg at 8:00 AM, 2:00 PM and 10:00 PM (used for anxiety and ordered on 10/03/14). Continued review revealed no evidence that a Gradual Dose Reduction had been completed since Resident #15 was admitted to the facility.</p> <p>Observation of Resident #15, on 12/02/15 at 4:25 PM, revealed Resident #15 was lying down on a bariatric bed. The resident was utilizing oxygen at this time. The resident was resting with his/her eyes closed.</p>	F 329	<p>psychotropic medication use.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not occur:</p> <p>Quarterly audits will be performed by IDT on all residents on psychotropic medication to ensure the appropriateness of the medication and timeliness of GDRs. IDT will also review appropriate interventions are in place that are addressing the behaviors of the mentioned residents and all new behaviors are being addressed in a non-psychotropic way first before administering medication for the behavior. GDRs and behaviors associated with the GDRs will be monitored by all staff. Behaviors will be addressed Monday-Friday during morning stand-up meeting and chart will be audited to ensure non-psychotropic intervention was tried first. Success will be gauged by IDT and monthly QA committee based on addressed behaviors and success of interventions. All issues will be addressed during monthly QA meeting for review.</p>		

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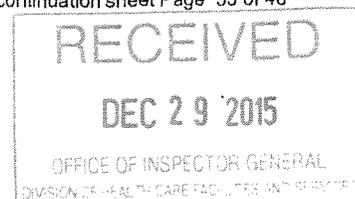
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F 329	Continued From page 33  Observation of Resident #15, on 12/03/15 at 8:10 AM, revealed Resident #15 was sitting up in bed in his/her room receiving care from staff and no behaviors were displayed by the resident. At 10:00 AM, the resident was lying down in bed with his/her eyes closed. At 12:00 PM the resident was eating his/her lunch meal while in bed with no behaviors displayed. At 1:30 PM the resident was lying down in bed with his/her eyes closed.  Observation and Interview with Resident #15, on 12/03/15 at 3:15 PM, revealed Resident #15 was lying down in bed. Resident #15 stated he/she knew what medications they were on, but was not aware he/she was on Zyprexa. Resident #15 stated he/she knew that Zoloft was for depression and had suffered depression for a long time. Resident #15 stated that he/she did not see things that were not there and was not sure what mood disorder meant.  Interview with Certified Nursing Assistant (CNA) #1, on 12/03/15 at 1:00 PM, revealed Resident #15 would refuse a shower some days, but did not have any behaviors. CNA #1 stated the CNAs documented the resident's behaviors in the computer system.  Review of Resident #15's Resident Behavior by day Chart, revealed Resident #15 was monitored for wandering, verbal behavior, physical and socially inappropriate behaviors, and rejection of care. Review of the Resident Behavior by day Chart, for the months of June, July, August, September, October 2015, and November 2015 revealed no documented behaviors except for one behavior documented for rejection of care.	F 329		



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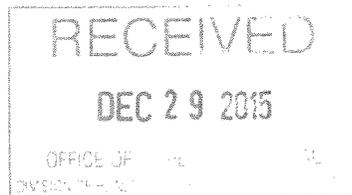
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F 329	Continued From page 34 Interview with Licensed Practical Nurse (LPN) #1, on 12/03/15 at 1:44 PM, revealed the nurses documented resident behaviors under the nursing notes and the C.N.A staff documented in the computer.  Review of Resident #15's Nurses Notes for the months of June, July, August, September, October, and November 2015, revealed only one behavior was documented by the nursing staff on 11/06/15 at 2:49 PM, revealed Resident #15 refused breathing treatments and stated to "get this thing off of me". The nurse educated the resident about the importance of adhering to the treatment schedule. It was documented that Resident #15 stated "I don't care, get this thing off of me".  Review of Resident #15's Psychiatric Follow up Evaluations, dated 05/28/15, 06/29/15, 07/23/15, 10/15/15 and 11/24/15, revealed per staff Resident #15 had "remained the same and was stable" without explanation.  Review of Resident #15's Psychiatric Follow up Evaluation, dated 05/28/15, revealed per staff Resident #15 remained the same, continued to believe that he/she was paralyzed and required staff to do everything for him/her, but was indeed capable of doing things for himself/herself. No issues with sleep or appetite. The Psychologist documented that Resident #15 continued to not do things when requested by staff and witnessed Resident #15 to say that he/she was paralyzed. The treatment plan would be the same. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Psychotic features, Anxiety, Cognitive Impairment and Mood Dysregulation.	F 329			



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F 329	Continued From page 35  Review of Resident #15's Psychiatric Follow up Evaluation, dated 06/29/15, revealed per staff Resident #15 remained unchanged, continued to believe that he/she was unable to do things for himself/herself (believe he/she was paralyzed). Resident #15 continued with staying in bed all the time per his/her preference, declined offers to get up or participate in activities. No issues with sleep or appetite. The treatment plan would remain the same. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Anxiety and Mood Dysregulation.  Review of Resident #15's Psychiatric Follow up Evaluation, dated 07/23/15, revealed per staff Resident #15 remained the same. No changes to mood or behavior reported. Resident #15 continued to stay in bed all the time, often refused to do anything for himself/herself as he/she claimed that he/she was paralyzed and was unable, though Resident #15 was able to move about without difficulty. No issues with sleep or appetite were reported. The treatment plan would remain the same. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Anxiety and Mood Dysregulation.  Review of Resident #15's Psychiatric Follow up Evaluation, dated 10/15/15, revealed per staff Resident #15 had been stable, no significant change in mood or behavior. Resident #15 continued to stay in bed almost all the time per his/her preference, relied on staff for activities of daily living and needed assistance with feeding as he/she was unable to perform the task. No issues with sleep or appetite reported. The treatment	F 329			



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F 329	<p>Continued From page 36</p> <p>plan would remain the same. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation (no risks were documented).</p> <p>Review of Resident #15's Psychiatric Follow up Evaluation, dated 11/26/15, revealed per staff Resident #15 had been stable, no significant change in mood or behavior. Resident #15 continued to remain in bed all the time per his/her preference and request. No issues with sleep or appetite were reported. The treatment plan would remain the same. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Cognitive Impairment and Mood Dysregulation.</p> <p>Interview with the Director of Nursing, on 12/03/15 at 3:41 PM, revealed Resident #15 had not yelled or cursed at her. The DON stated she had not noticed any anxiety in Resident #15 and personally had not witnessed any behaviors from Resident #15. Resident #15 slept a lot and that could be from the Xanax that he/she was receiving. The DON stated she could see there was no evidence to show that Resident #15 should be on the psychotropic medications. The DON stated she had not completed any chart audits for psychotropics and she could not understand how Resident #15's GDR was missed.</p> <p>2. Review of Resident #1's clinical record revealed the facility admitted the resident on 05/21/13 with diagnoses of Alzheimer's Disease, Dementia with Behavior, Anxiety, Major Depressive Disorder and Chronic Pain. Review of Resident #1's MDS Annual Assessment, dated</p>	F 329			

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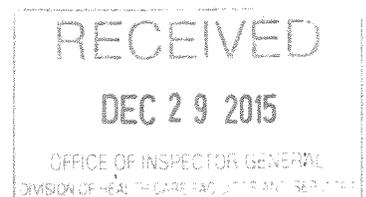
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F 329	<p>Continued From page 37</p> <p>11/18/15, revealed the facility assessed Resident #1 utilizing the BIMS exam with a score of 99 which meant the resident could not complete the interview task and was not interviewable. Review of Resident #1's care plan, dated 02/07/15, revealed Resident #1 was care planned for yelling out continuously.</p> <p>Further review of Resident #1's Physician Orders, dated 12/02/15 through 12/31/15, revealed Resident #1 was prescribed Aricept 10 mg at bedtime (used for Alzheimer's Disease and ordered on 01/08/14), Seroquel 25 mg daily, then Seroquel 125 mg at 4:00 PM daily and Seroquel 125 mg at bedtime daily (used for Major Depressive Disorder and ordered on 04/29/15), Buspar 5 mg twice a day (used for anxiety and ordered on 07/23/15), Zoloft 50 mg daily (used for Depression and ordered on 09/24/15), and, Depakote Sprinkles 125 mg three times a day (used for mood disorder and ordered on 10/30/15).</p> <p>Observation of Resident #1, on 12/01/15 at 11:20 PM, 12:05 PM, 1:20 PM and 3:45 PM; on 12/02/15 at 8:10 AM, 8:45 AM, 9:42 AM, 2:15 PM and 4:15 PM; and, on 12/03/15 at 8:10 AM, revealed no behaviors were displayed by the resident.</p> <p>Review of Resident #1's Resident Behavior by day Chart, revealed no behaviors were documented for the months of June, July, August, September, October and November 2015.</p> <p>Review of Resident #1's Nurses Notes, from June 2015 through December 2015, revealed no behaviors were documented by staff.</p>	F 329			

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F 329	<p>Continued From page 38</p> <p>Review of Resident #1's Psychiatric Follow-up Evaluation, dated 07/23/15, revealed per staff Resident #1 had been better, no recent reports of yelling out or other behaviors. No problems with sleep or appetite reported. The Treatment plan was to lower Buspar to 5 mg twice a day. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Cognitive Impairment, Mood Dysregulation and Behavioral Disturbance.</p> <p>Review of Resident #1's Psychiatric Follow-up Evaluation, dated 08/20/15, revealed per staff Resident #1 had again been yelling out, staff were unclear if the behavior reappearing had anything to do with the GDR done at the last visit and had requested a review of medications. Staff reported that the behavior was not as severe as it had been in the past, but would like things reviewed to possibly stop things from exacerbating. No problems with sleep or appetite reported. The Treatment plan was to get a valproic level ten (10) to twelve (12) hours from last dose administered, then increase the Depakote. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Cognitive Impairment, Mood Dysregulation and Behavioral Disturbance.</p> <p>Review of Resident #1's Psychiatric Follow-up Evaluation, dated 09/17/15, revealed per staff Resident #1's yelling out behaviors had become worse since the last visit. Staff reported that the behaviors had especially exacerbated in the late afternoon/evening. Staff reported often re-direction was unsuccessful. Resident #1 seemed to exhibit behavior regardless of up in chair or in bed. No problems with sleep or</p>	F 329		



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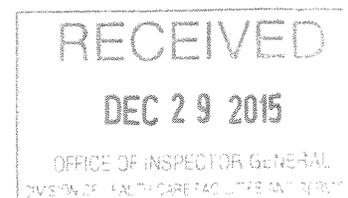
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F 329	<p>Continued From page 39</p> <p>appetite. The treatment plan was to discontinue Nuedexta and to add Depakote 125 mg twice a day and to check valproic acid level in one (1) week. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Cognitive Impairment, Mood Dysregulation and Behavioral Disturbance.</p> <p>Review of Resident #1's Psychiatric Follow-up Evaluation, dated 10/15/15, revealed per staff Resident #1 yelling out behaviors had been somewhat better, the behavior still occurred, but seemed to be happening less often. Staff reported Resident #1 appeared to be tolerating Depakote without adverse response. No problems with sleep or appetite reported. The treatment plan was to increase Depakote 125 mg to three (3) times a day and in one week check valproic acid level. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Cognitive Impairment, Mood Dysregulation and Behavioral Disturbance.</p> <p>Review of Resident #1's Psychiatric Follow-up Evaluation, dated 11/24/15, revealed per staff Resident #1 had been calmer and had not been yelling out as often. Staff reported that Resident #1 would yell, but was happening much less often and was more easily calmed. No problems with sleep and appetite reported. The treatment plan was to continue medication orders. A trial dose reduction of the psychiatric medications listed were contraindicated secondary to the risk for exacerbation of Cognitive Impairment, Mood Dysregulation and Behavioral Disturbance.</p> <p>Interview with CNA #1, on 12/03/15 at 1:00 PM,</p>	F 329			

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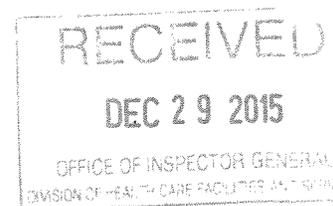
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F 329	<p>Continued From page 40</p> <p>revealed Resident #1 had some behaviors such as wanting to lay down, then would scream out that he/she wanted to get back up.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/03/15 at 1:44 PM, revealed Resident #1 had behaviors such as yelling out for help. Resident #1 may say that he/she was in pain or needed to go to the bathroom. Then there were times when he/she did not know why they were yelling.</p> <p>Interview with the DON, on 12/03/15 at 3:41 PM, revealed there was no evidence to show that Resident #1 really needed to be on his/her medications. The DON stated they did decrease his/her Buspar and Seroquel and discontinued the Zoloft. Further interview with the DON, revealed the Psychiatric Nurse reviewed the chart and had not asked her to print out behavior reports. The Nurse would ask how the residents were doing. The DON stated the Psychiatrist did not attend the QA. The DON stated there was also a problem with the charting. Staff needed to be reeducated properly about the difference between a behavior and disease process. There was also no evidence to show the residents were having behaviors.</p> <p>Interview with the Advanced Practice Registered Nurse (APRN), on 12/03/15 at 2:03 PM, revealed she tried to leave the Psychiatrist with the responsibility of following residents with behaviors. The APRN stated that when there was a recommendation for GDR, she should try to complete the recommendation. The APRN stated after review of the Resident Behavior by day Chart reports she could see that the behavior monitoring needed improvement.</p>	F 329			



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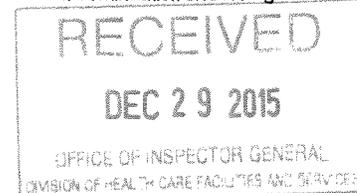
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F 329	Continued From page 41  Interview with the Social Services Director, on 12/03/15 at 4:35 PM, revealed the Psychologist came into the building once a month. Social Services stated she printed off the residents weights for the Doctor. She did not print off behaviors or nursing notes. She stated the Doctor did not have access to the computer system. The Social Services Director stated she and a nurse would talk to the Psychologist about resident behaviors. The Social Services Director stated she had reported to the Psychologist that Resident #1 and #15 were fine with no concerns. She stated that she had not recognized that the staff was not documenting behaviors and if she had recognized that she would have talked to the Director of Nursing and Staff Development about additional education.  Interview with the Psychiatrist, on 12/03/15 at 3:00 PM, revealed her nurse would go to facilities monthly to look at resident notes and talk to staff. The Psychiatrist stated sometimes when there were no notes to review they would talk to the staff. They would ask questions about how the residents were acting and what was going on with the resident.  On 12/07/15 at 10:07 AM, after review of a voice message, revealed the Psychiatrist wanted further correspondence Post Survey, on 12/04/15 at 11:11 AM, revealed her assistant (Nurse) was meeting at the facility prior to rounds with the Director of Nursing, Minimum Data Set (MDS) Coordinator and Social Services Director. The Assistant had no access to the computer and the facility was not able to supply her with access, so the Assistant only received her report from the meeting in which she had with staff.	F 329			



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F 329	Continued From page 42	F 329		
F 514 SS=D	<p>An Attempt to reach the Psychiatrist for additional information via telephone, on 12/07/15 at 10:45 AM and 3:35 PM was unsuccessful.</p> <p>Interview with the Administrator, on 12/03/15 at 2:47 PM, revealed the facility scores for psychotropics were high. The Administrator stated he became aware that the facility had problems with psychotropics about four (4) weeks ago. The Administrator further stated the facility should have attempted Gradual Dose Reductions for the benefit of the residents.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to maintain an accurate clinical record for</p>	F 514	<p>F 514</p> <p>1. Corrective action for the resident affected by the alleged deficient practice:  Skin assessment was done on resident #1 with no new significant change noted due to the alleged deficient practice.</p>	12.25.15



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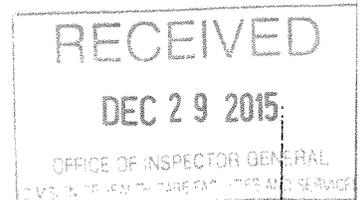
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F 514	<p>Continued From page 43</p> <p>one (1) of fifteen (15) sampled residents, (Resident #1). The nurses documented Resident #1 was wearing geri sleeves during the survey; however, observation and interview revealed the staff failed to put the geri sleeves on Resident #1.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Clinical Records, effective 02/20/12, revealed to establish guidelines for documentation in the resident's clinical record that reflected the nursing process and revealed that residents received care that met acceptable standards of practice. It was the policy of the facility to maintain a clinical record on each resident that was complete and accurately documented. Documentation should provide a picture of the resident's progress, including response to treatment, change in condition and changes in treatment.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 05/21/13 with diagnoses of Alzheimer's Disease, Dementia with Behavior, Anxiety, Major Depressive Disorder and Chronic Pain. Review of Resident #1's MDS Annual Assessment, dated 11/18/15, revealed the facility assessed Resident #1 utilizing the BIMS exam with a score of 99 which meant the resident could not complete the interview task and was not interviewable.</p> <p>Review of Resident #1's physician orders, dated 12/01/15, revealed the staff was place geri sleeves on Resident #1 bilateral arms.</p> <p>Observation of Resident #1's arms, on 12/01/15 at 12:05 PM, 1:20 PM and 3:45 PM, revealed no geri-sleeves on Resident #1's arms.</p>	F 514	<p>2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:</p> <p>TAR audit and done on all residents with care plans for Geri-sleeves. Audit showed placement of Geri-sleeves were charted on. DON and administrator checked resident for accuracy of documentation and found it to be accurate.</p> <p>3. Measures/Systematic changes put in place to assure the alleged deficient practice does not re occur:</p> <p>Education was done by SDC on policy and procedure of documentation of treatments. Monthly audits will be done on accuracy of TAR documentation X3 months to ensure documentation is accurate. Audits will then be quarterly X3 quarters.</p>	

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F 514	<p>Continued From page 44</p> <p>Observation of Resident #1's arms, on 12/02/14 at 8:45 AM, 9:42 AM, 2:15 PM and 4:15 PM, revealed no geri-sleeves on Resident #1's arms.</p> <p>Review of Resident #1's Medication Administration Record (MAR), dated 12/01/15 and 12/02/15, revealed nursing staff signed that the geri-sleeves were applied to Resident #1's arms.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 12/03/15 at 1:00 PM, revealed she worked on 12/02/15 with Resident #1 and was not aware Resident #1 was to wear geri-sleeves. CNA #1 stated she was to review her CNA plan daily, but had not reviewed the plan for Resident #1. CNA #1 stated geri-sleeves were used to prevent bruising and scratching.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/03/15 at 1:44 PM, revealed she did not work on 12/01/15 and 12/02/15, but knew that the nursing staff was to go check that the item had been placed on the resident before a nurse signed that it had been done. LPN #1, stated if the nursing staff had documented the geri sleeves were there when it was not, then the record was not accurate.</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 3:41 PM, revealed the nursing staff should not document that something was done when it was not. The nursing staff should have signed their initials and then circled their initials and wrote a note on the back of the treatment record as to why the geri sleeves were not in place. However, the DON stated it was an assumption the record was accurate if the nurses</p>	F 514	<p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not occur:</p> <p>Monthly audits will be done on accuracy of TAR documentation X3 months to ensure documentation is accurate. Audits will then be quarterly X3 quarters. All issues will be brought to the attention of the DON, any further issues will be brought to the monthly QA committee for review/recommendations.</p>	



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F 514	Continued From page 46 documented that something was done.	F 514			

