

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

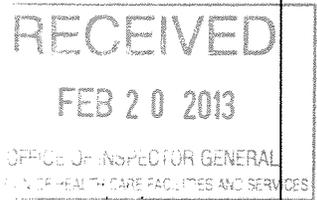
PRINTED: 01/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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F 000	INITIAL COMMENTS A standard health survey was conducted on 01/08/13-01/10/13 and a Life Safety Code survey was conducted on 01/08/13 with deficiencies cited at the highest scope and severity at an "F". The facility had the opportunity to correct the deficiencies before imposition of remedies would be recommended.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.	F 156	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F156 Notice of Rights, Rules, Services, 2/18/13 Charges It is the practice of Kindred Transitional Care and Rehabilitation – Northfield to notify each resident, in the appropriate format, when services are no longer covered under Medicare. The SNF Determination on Continued Stay denial notice is being sent to residents or responsible party when resident no longer qualifies for Medicare benefits and is staying at the center or leaves the SNF with Medicare days remaining. The facility provided unsampled residents A, B, and C with appropriate letters on 1/14/13 addressing the information on how to contact the Quality Improvement Organization.	



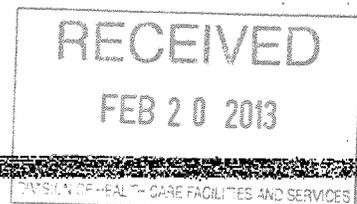
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dennis McNaught</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2/14/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements</p>	F 156	<p>Resident #14, 15, and A received medicare non coverage letter with appropriate appeal rights were issued to them on 1/14/13.</p> <p>An audit was completed on all residents within the last 90 days who were discharged to make sure letters were issued. Any resident found to have no letter will have a corrected letter sent out by 02/12/13. The letters of appeal that the facility provides to the residents have been revised to reflect the name, address, and phone number of the Quality Improvement Organization. This was completed on 01/31/13.</p> <p>Social Services and or the assistant social services will maintain a tracking form to ensure signed letters are returned.</p> <p>The SDC educated social services, case management, and the BOM on appeal letters, denial letters, and tracking forms. Staff was determined competent through re-verbalization of instructions and testing of knowledge.</p> <p>Case Management starting 01/17/2013 will track all letters on a form to ensure they are all returned. The Business Office Manager will audit the Case Manager on a monthly basis for the next 6 months to ensure all letters that are sent out are returned and signed.</p> <p>The Business Office Manager and/or Case Manager will present the results of the tracking form to the Performance Improvement committee for review monthly for the next 6 months and will provide appropriate actions as needed. The Executive Director is responsible for overall compliance.</p>	



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F 156	<p>Continued From page 2</p> <p>specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed record review and interview, it was determined the facility failed to ensure Medicare A residents were issued a "Notice of Medicare Provider Non-coverage" letter upon termination of all Medicare Part A services for three (3) of three (3) closed record reviewed. The facility failed to issue a non-coverage letter, with information on beneficiary appeal rights for those residents that were discharged from the facility after Medicare Part A services were terminated. The facility only provided that information to those</p>	F 156		

If continuation sheet Page 3 of 39

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

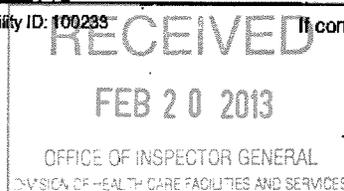
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F 156	<p>Continued From page 3.</p> <p>residents who continued to reside in the facility after Medicare Part A services were terminated.</p> <p>The findings include:</p> <p>The facility did not have a specific policy related to Non-coverage letters. The corporate representative indicated the facility followed the federal regulation guidelines for Medicare beneficiaries. The facility stated no resident had requested an appeal.</p> <p>Review of the facility's admission/financial agreement revealed the facility provided information on how the resident could apply for benefits under Medicare and Medicaid. A copy of a blank Notice of Medicare Non-coverage letter was included in the admission packet and provided to the resident or responsible party during the admission process.</p> <p>1. A closed record review of Resident #14's clinical record revealed the facility admitted the resident on 11/20/12 for skilled services under Medicare Part A. The record revealed the resident was discharged to home on 12/04/12 with remaining skilled days left. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>2. A closed record review of Resident #15's clinical record revealed the facility admitted the resident on 07/10/12 for skilled services under Medicare Part A. The record revealed the resident was discharged from Medicare Part A skilled services on 08/17/12 with remaining skilled days left. However, the facility failed to issue a</p>	F 156		



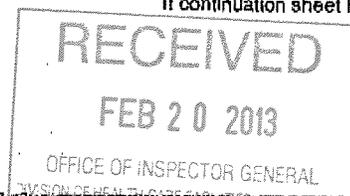
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F 156	<p>Continued From page 4</p> <p>Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>3. A closed record review for Unsampled Resident A revealed the facility admitted the resident for skilled services under Medicare Part A. The record revealed the resident was discharged to home on 08/26/12 with remaining skilled days left. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>Interview with the Case Manager/MDS Coordinator, on 01/09/13 at 11:10 AM, revealed she was responsible for Liability Notices & Beneficiary Appeal letters after a resident's Medicare Part A skilled services were terminated. She stated she only issued those letters to residents who will remain in the facility under a different payor source. She said she had not provided the notice of non-coverage to residents who were discharged from the facility even though the residents had not exhausted all their skilled days.</p> <p>Review of the Liability Notices & Beneficiary Appeal letters provided to Unsampled residents A, B, and C (who still reside in the nursing facility) revealed the notices had information regarding appeal rights; however, did not provide a telephone number or address on how to contact the Quality Improvement Organization (independent reviewer authorized by Medicare to review the decision to end skilled services).</p> <p>Continued Interview with the Case Manager, on 01/10/13 at 11:00 AM, revealed the former case manager provided the notices and she was given</p>	F 156		



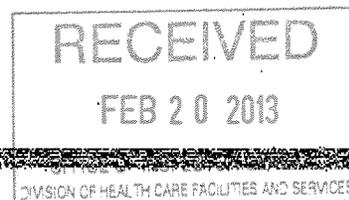
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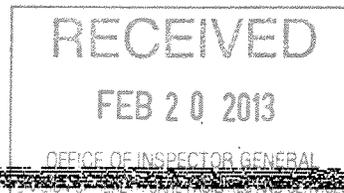
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F 156	Continued From page 5 the responsible about a month ago. She stated she received a quick training from the former case worker. She was told the Medicare notices were not provided to residents that were going home, even if they had skilled Medicare days left. She stated there was an online updated information regarding Non-coverage letters on 10/04/12. However, that was before this case manager was responsible for the notices. Review of the 10/04/12 corporate online update information regarding Non-coverage letters revealed a quick grid reference that indicated Non-coverage notices were to be provided to all residents receiving Medicare Part A skilled coverage that had benefit days remaining. The grid included those residents who were discharged home or to another facility.	F 156		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to identify and assess behavior problems for two (2) of sixteen (16) sampled residents and eight (8) unsampled residents (Residents #4 and #9). The facility failed to address Resident #4's behaviors of noncompliance with a treatment plan, distress over family relationships, sadness, and long	F 250	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F250 Provision of Medically related Social Service 2/18/13 It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to identify and meet the needs of residents. The Social Service Director and Social Service Assistant were in serviced by the Executive Director on 2/4/13 on the policy regarding identifying and meeting needs of residents.	



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F 250	<p>Continued From page 6</p> <p>distance from family and friends. The facility failed to address Resident #9's noncompliance with safety in order to improve the resident's ability to manage the environment safely.</p> <p>The findings include:</p> <p>1. Observation of Resident #4, on 01/09/13 at 9:00 AM, revealed the resident was teary-eyed and wiping eyes when talking about being far from home and family.</p> <p>Interview with Resident #4, on 01/09/13 at 9:00 AM, revealed the resident was from another state and missed contact with family and friends. The resident stated support from the family was difficult due to the distance from home and was concerned regarding assets the family might be taking. The resident verbalized feeling anxious and depressed and wanted to go home as soon as possible. The resident stated a discharge had been planned for the upcoming weekend; however, the resident had not made enough progress so the discharge was canceled. The resident revealed feelings of disappointment and distress over the events and stated a long hospital stay when very ill made things worse.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Respiratory Failure, Congestive Heart Failure, Anxiety and Depression. The facility completed a quarterly Minimum Data Set (MDS) assessment of the resident on 11/30/12 which revealed the resident was cognitively intact, required extensive assistance with all care needs,</p>	F 250	<p>The issue relating to resident #4 is being addressed and discharge to a center closer to home is planned for the first weekend in February. Resident #9 is working with social services his center appointed staff Angel to remove items from the room. The Social Service Director and Social Service assistant have been in serviced on documentation expectations and care plan process by the SDC on 1/31/13</p> <p>An audit of 100% the residents was completed by 2/12/13 on the content of Social Services documentation as it pertains to the resident needs.</p> <p>The results of the audit will be discussed at the monthly PI meeting for twelve months by the Social Service Director. The Executive Director is responsible to ensure the standard has been met and is overall responsible for compliance.</p>	



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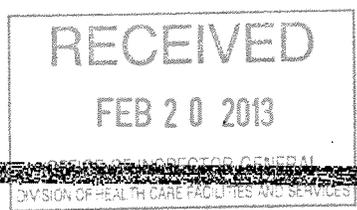
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F 250	<p>Continued From page 7</p> <p>felt tired and down and received antianxiety medication and an antidepressant.</p> <p>Review of the care plan for Resident #4, revealed the resident received medications for Anxiety and Depression; however, the resident's anxiety and depression and the behaviors resulting from the resident's medical condition and long hospital stay were not addressed except for the resident cursing at the staff.</p> <p>Review of the notes written by the psychiatric team on 09/19/12, revealed the resident was focused on the conflict between children, thought the son had stolen money and was tearful and crying. On 11/29/12, the notes indicated the resident was distressed especially due to the upcoming holidays. In addition, the resident was worried regarding the removal of the tracheostomy tube coming soon.</p> <p>Interview with the Social Service Director (SSD), on 01/09/13 at 5:00 PM, revealed Resident #4's discharge was postponed due to lack of progress with the resident becoming more independent. He stated the resident refused to participate in the restorative program frequently after discharged by physical and occupational therapy. He was not able to locate a care plan addressing the resident's behaviors or an update of the discharge plan last addressed on 09/20/12. He stated the care plan should have addressed the resident's anxiety and depression as well as the discharge plan changes. He indicated he was the team member responsible for monitoring residents' behaviors and psychotropic medications.</p>	F 250		
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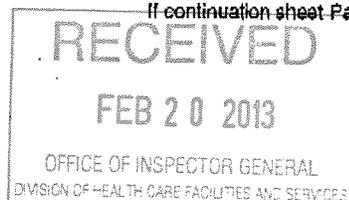
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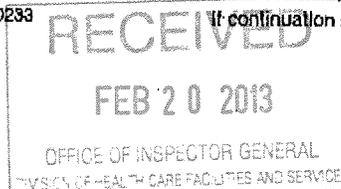
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F 250	<p>Continued From page 8</p> <p>Interview with the Director of Nursing (DON), on 01/10/13 at 9:00 AM PM, revealed her expectation was that the care plan team would address the residents needs. She stated she did not review resident care plans for completeness.</p> <p>2. Observation of Resident #9, on 01/08/13 at 10:30 AM, revealed the resident's room contained three bookshelves, a plastic multi-drawer storage unit, a large reclining chair, a dresser, and numerous bags of personal clothing and items stored on the floor and under the bed. In addition, there were papers, books, and magazines on the floor. The room was a semi-private room and the other bed was not occupied.</p> <p>Interview with Resident #9, on 01/08/13 at 10:30 AM, revealed the resident knew the room was crowded. The resident stated that the items made the room more home-like, and the family would bring in anything needed. The resident stated the facility had asked several times for the clutter to be removed; however, the resident had ignored the requests. The resident was agreeable to decreasing the clutter after fire safety issues were discussed.</p> <p>Review of the clinical record for Resident #9, revealed the resident had diagnoses of Anxiety and Depression. The facility completed a quarterly MDS assessment on the resident on 11/21/12 which revealed the resident was cognitively intact and required extensive assistance with care needs. The resident received an anti-anxiety medication and an antidepressant. The resident complained of</p>	F 250		



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F 250	Continued From page 9 tiredness, feeling down and had difficulty sleeping. Review of the care plan for Resident #9, revealed the hoarding behavior of the resident was not addressed. Interview with the SSD, on 01/09/13 at 9:45 AM, revealed Resident #9 did not have a care plan to address the clutter problem. He stated the resident was uncooperative with the facility requests. He revealed the problem should be addressed by the care plan team to develop a plan to assist Resident #9 in reducing the clutter in the room, making the room safer. Interview with the DON, on 01/09/13 at 3:50 PM, revealed her expectation was that the residents' care plans should address problems and the hoarding behavior should have been addressed. Interview with the Social Services Director, on 01/09/13 at 5:00 PM, revealed the facility did not have a policy for management of resident behaviors.	F 250		
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. 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.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F279 Develop Comprehensive Care Plans It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to have comprehensive care plans that include	2/18/13



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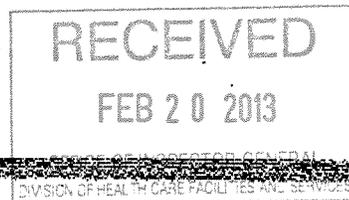
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F 279	<p>Continued From page 10</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services 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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record view, and review of the facility's policy, the facility failed to develop comprehensive care plans based on the results of the Minimum Data Set (MDS) assessments for two (2) of sixteen (16) sampled residents and eight (8) unsampled residents, Residents #3 and #4.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled Care Plans: Resident Care/Assessments, dated 01/07/12, revealed the Plan of Care was developed within seven (7) days after completion of the MDS and Care Area Assessment (CAA). The care plan would address the resident's needs, strengths, and preferences identified in the comprehensive assessment. The resident's condition and the effectiveness of the care plan would be monitored by a team of qualified persons who revised the care plan quarterly, annually, in the event of a significant change in the resident's condition, and more frequently if needed.</p>	F 279	<p>measurable objectives and timelines to meet resident's medical and mental needs.</p> <p>The Interdisciplinary Care Planning team will assess residents and complete a comprehensive care plan based on the assessment.</p> <p>The care plan of Resident #3 was updated to reflect at risk for falls. Appropriate interventions, goals, and approaches were placed on care plan of Resident #3 by MDS Care Plan Coordinator. This was completed on 01/10/2013. Resident #4 met with IDT on 01/14/2013 and the family was called to plan a discharge for the resident. A facility closer to the family was found in Tennessee, and discharge planning was started on 01/15/2013 by social services.</p> <p>All Nursing staff education was conducted on proper care planning processes by the Staff Development Coordinator. Staff educated on measurable objectives, goals & proper interventions. Staff educated on identifying psychosocial needs appropriately and documenting the needs on the care plan with appropriate interventions by the Staff Development Coordinator. Nursing and social services staff completed education on 01/29/2013. Education was completed by the Director of Nursing Services and the SDC.</p> <p>All residents were re-assessed for risk for falls on 01/29/13 by the Director of Nursing Services, the Assistant Director of Nursing and the MDS Care Plan Coordinator. All residents at risk for falls have care plan updates completed by 01/29/13. Any resident who triggers during the MDS</p>	
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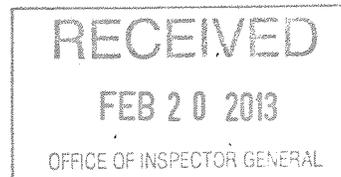
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F 279	<p>Continued From page 11</p> <p>1. Record review revealed Resident #3 was admitted to the facility on 10/25/05 with diagnoses of: Generalized Pain; Anemia; Aphasia; Hypertension; Type II Diabetes; Seizure Disorder; and Esophageal Reflux. Review of the MDS Annual Assessment, dated 12/12/2012, revealed Resident #3 triggered for falls within the CAA summary. Review of Resident #3's comprehensive care plan, dated 12/12/12, revealed a care plan was not developed for falls. Further review of the care plan and annual MDS assessment, dated 12/12/12, revealed Resident #3 required extensive assistance with Activities of Daily Living (ADLs), including transfer which required two (2) staff members using a mechanical lift.</p> <p>Observation, on 01/08/13 at 12: 01 PM, revealed Resident #3 was in a geri chair in the day area adjacent to the north nurses' station. Resident #3 was dressed in a blue smock-type dress, and covered with a blanket. Enteral feeding (Glucerna 1.2) was infusing per pump at 60cc/hr. Resident #3's eyes were open.</p> <p>Interview, on 01/09/13 at 11:45 AM, with Certified Nursing Asslstant (CNA) #4 revealed a mechanical lift was used when transferring Resident #3.</p> <p>Interview, on 01/10/13 at 10:40 AM, with the MDS Coordinator, revealed Resident #3 should have been care planned for falls based on the results of the annual MDS assessment. In addition, she said the resident's history of a selzure disorder, his/her vsual limitations, aphasia, and his/her total dependency on staff for all ADLs including extensive assistance with transfers placed</p>	F 279	<p>assessment process will have a care plan completed for all areas triggered. Beginning 01/10/2013 and ongoing.</p> <p>All residents were assessed for psychosocial needs on 01/18/2013 by the at risk IDT team. All residents identified upon assessment were care planned and appropriate interventions were put in place. This was completed on 01/18/2013.</p> <p>The SDC educated all licensed staff on care planning processes, identifying psychosocial needs and appropriate fall assessments. The education was verified through testing to ensure all staff were competent in the care plan process. This was completed on 01/18/2013.</p> <p>The Director of Nursing or clinical case manager will monitor through resident record review (care plan), monthly for three months, then at least quarterly, to assure each resident has a comprehensive care plan. The Executive Director is responsible for overall compliance.</p>	



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F 279	<p>Continued From page 12</p> <p>him/her at risk for falls. The MDS Coordinator stated the MDS staff, licensed nurses, and other Interdisciplinary Team (IDT) members were responsible for ensuring comprehensive care plans were completed and were current. The MDS coordinator did not know exactly why a falls care plan did not exist, only that this triggered area was apparently missed when the care plan was developed.</p> <p>Interview, on 01/10/13 at 10: 55 AM, with the Director of Nurses (DON) revealed if a problem triggered during an initial, annual, or quarterly MDS assessment, it should be care planned by the staff member who completed the assessment. However, the MDS Nurse was responsible for ensuring all comprehensive care plans were complete. If a resident was identified to be at risk for falls, a risk assessment should be conducted by the unit nursing staff, the nurse who completed that assessment should update the care plan to reflect the interventions initiated to protect the resident. The ultimate goal of a fall care plan was to ensure the resident was protected from injury.</p> <p>2. Observation of Resident #4, on 01/08/13 at 10:30 AM, revealed the resident was observed to be distressed and teary eyed remembering the long illness that brought the resident to the facility.</p> <p>Interview with Resident #4, on 01/08/13 at 10:30 AM, revealed the resident felt sadness and anxiety over being away from family living in another state. The resident stated family</p>	F 279		

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F 279	<p>Continued From page 13</p> <p>support was limited and there were problems with a member of the family stealing money.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Anxiety, Depression and Respiratory Failure. The facility completed an admission MDS assessment on the resident on 09/14/12 which revealed the resident felt down, tired and took little pleasure in interests. The resident received antidepressants and anti-anxiety medications.</p> <p>Review of the care plan for Resident #4, revealed the resident's anxiety and depression symptoms were not addressed on the care plan.</p> <p>Interview with the Social Services Director, on 01/09/13 at 5:00 PM, revealed he was aware of Resident #4's behaviors; however, he did not develop a care plan for the behaviors and had no explanation. He stated the behaviors should have been addressed to assist the resident in coping with admission.</p> <p>Interview with the MDS Coordinator, on 01/10/13 at 10:20 AM, revealed each discipline was responsible to develop a care plan and social services should have addressed the behaviors. She stated the care plan team normally addressed behaviors and Resident #4 should have been addressed. She indicated that she does not oversee the care plans of other disciplines.</p> <p>Interview with the Director of Nursing, on 01/10/13 at 10:40 AM, revealed Resident #4's behaviors should have been addressed by the</p>	F 279		

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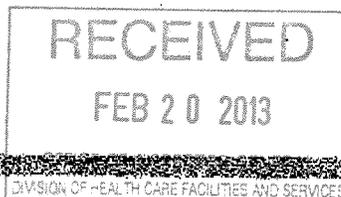
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F 279	Continued From page 14 care plan team. She revealed she did not oversee the care plans.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise 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 facility policy review, it was determined the facility failed to revise four (4) of sixteen (16) sampled residents and eight (8) unsampled residents (Residents #4, 5, 6, and 9) care plans. The facility failed to revise the care plan for Resident #4 when tracheostomy tube was	F 280	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F280 Right to Participate in Care Planning It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to allow residents to participate in care planning reviews. Residents 4, 5, 6, and 9 care plans were assessed and updated to reflect all appropriate interventions, goals, and approaches. The MDS Care plan coordinator completed on 01/14/2013 All residents with non-compliance with plans of care were assessed and areas were address on the care plans by the MDS care plan coordinator and this was completed on 01/29/2013. All residents identified as having psychosocial needs were care planned appropriately with measurable goals, interventions, and approaches. This was completed by Social Services on 01/18/2013.	02/18/2013



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F 280	<p>Continued From page 15 removed, when tube feeding was discontinued and when the resident was discharged from therapies and transferred to restorative nursing. The facility failed to revise the care plan for Resident #9 when hoarding behaviors began.</p> <p>Findings include:</p> <p>Review of the facility's policy regarding Quality of Care, Revised 08/31/11, revealed a decline or lack of improvement was unavoidable if the results of the Interventions were evaluated and revised, if necessary.</p> <p>Review of the facility's policy regarding Care Plans, dated 01/07/12, revealed the care plan would be consistent with resident's specific conditions, needs, risks, behaviors, preferences and revised to reflect the resident's current status.</p> <p>1. Observation of Resident #4, on 01/08/13 at 10:30 AM, revealed the resident did not have a tracheostomy or a tube feeding. The resident had nasal oxygen in place and the tracheostomy site was covered.</p> <p>Interview with Resident #4, on 01/08/13 at 10:30 AM, revealed the resident no longer had a tracheostomy and did not receive tube feedings.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Respiratory Failure, Congestive Heart Failure, Depression and Anxiety. The facility completed an admission Minimum Data</p>	F 280	<p>All residents were assessed by the MDS care plan coordinator, Director of Nursing Services and Assistant Director of Nursing using bladder evaluation tools for appropriate elimination status. Care plans were updated with appropriate interventions. This was completed by 01/22/2013. All staff was educated by the SDC on 01/29/2013 for appropriate assessment and care planning of elimination status and toileting needs. The SDC tested staff competency through tests and re-verbalization of instructions regarding appropriate assessments and care plan techniques on elimination status and toileting needs. This was completed on 01/29/2013.</p> <p>Review of all care plans was completed by the MDS care plan coordinator on 01/29/2013. The review was to assess that all interventions, goals, and approaches are appropriate. All care plans were updated that were identified to have a problem by the MDS care plan coordinator.</p> <p>All Nursing staff education was conducted on proper care planning processes by the SDC. Staff was educated on measurable objectives, goals & proper interventions. Staff educated on identifying goals and interventions that need to be discontinued and developing new appropriate interventions. Education with all staff was completed on 01/29/2013 by the SDC. Testing was completed on 01/29/2013 to assess staff competency and education knowledge.</p>	

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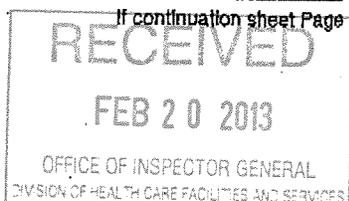
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F 280	<p>Continued From page 16</p> <p>Set (MDS) assessment on 09/14/12 which revealed the resident had feelings of being down, tired, and had little interest in any events. The resident received tube feeding and had a tracheostomy. The resident was not compliant with restorative nursing interventions.</p> <p>Review of the Psychiatrist notes for 10/21/12, revealed Resident #4 expressed distress regarding the relationship with the family. On 11/29/12, the resident revealed increased anxiety and sadness regarding the upcoming holidays away from family and concern over safety regarding the plan to remove the tracheostomy. On 12/20/12, the resident was agitated and upset with the staff over the care received.</p> <p>Review of the Nursing notes for 12/04/12, revealed Resident #4 was placed in contact precautions for a Urinary Tract Infection requiring isolation.</p> <p>Review of Resident #4's care plan, revealed the resident's concerns regarding the holidays, concerns regarding the removal of the tracheostomy, noncompliance with restorative nursing and the effects of being in isolation were not addressed by the interdisciplinary care plan team.</p> <p>2. Observation of Resident #9, on 01/08/12 at 10:30 AM, revealed the resident in bed with the head of the bed elevated. The resident's room was cluttered with extra furniture filled with personal items, books, magazines and papers. There were numerous bags of belongings stored on the floor and under the bed.</p>	F 280	<p>The Director of Nursing or Assistant Director of Nursing will monitor and review the letters sent by MDS to residents and families and through record review at least monthly for twelve months to assure the special needs of residents are addressed. Findings of audits completed after initial audits from 1/29/13 will be presented at PI committee monthly for 12 months by the DNS. The Executive Director is responsible for overall compliance</p> <p>The Director of Nursing or Clinical Case Manager will monitor through record review at least monthly for three months, then at least quarterly, to assure the special needs of residents are addressed. The Executive Director is responsible for overall compliance</p>	
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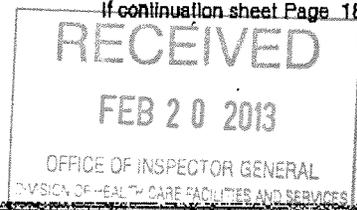
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F 280	<p>Continued From page 17</p> <p>Interview with Resident #9, on 01/09/13 at 8:25 AM, revealed the resident had discussed the condition of the room with the Social Services Director; however, there were no plans to resolve the clutter. The resident indicated a willingness to resolve the concerns.</p> <p>Review of the clinical record for Resident #9, revealed the facility admitted the resident with diagnoses of Depression, Anxiety, Diabetes and Chronic Obstructive Pulmonary Disease. The facility completed a quarterly MDS assessment on 11/21/12 which revealed the resident was cognitively intact, required extensive assistance with care needs, and was incontinent.</p> <p>Review of the care plan for Resident #9, revealed the resident's behaviors of hoarding were not addressed.</p> <p>Interview with the Social Services Director, on 01/09/13 at 5:00 PM, revealed no plans were in place to resolve the clutter in Resident #9's room. He stated attempts had been made in the past to have family members remove items; however, the attempts were not successful. He stated the concern was not on the care plan nor had the interventions been revised to attempt to unclutter the resident's room. He stated no current plans were in place.</p> <p>3. Observation of Resident #5, on 01/08/13 at 11:00 AM, revealed the resident sitting in a wheelchair in the day room. A Gastro-feeding pump was turned on with a rate of forty (40) milliliters (cc's) an hour connected to the Gastric</p>	F 280		
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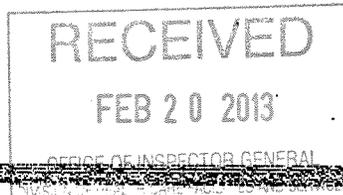
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F 280	<p>Continued From page 18</p> <p>tube of Resident #5. Observation, on 01/08/13 at 2:35 PM, revealed Resident #5 in bed, sleeping, with an infusion pump for tube feeding going at a rate of forty (40) cc's an hour. There were no observations of Resident #5 eating food by mouth.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 12/09/08 with the diagnoses of Malignant Neoplasm of the Brain, Kidney Failure, Meningococcal Infection, Venous Thrombosis, Hypertension, Diabetes and a Seizure Disorder. The facility completed an annual Minimum Data Set (MDS) assessment on 01/17/12 which revealed the resident was not interviewable and had a feeding tube. Resident #5 received tube feedings. Resident #5 received nothing by mouth (NPO) since 08/13/12.</p> <p>Review of the care plan for Resident #5 revealed a self care deficit identified on 03/27/09 which required assistance with the activities of daily living (ADL's), including eating. An approach dated 04/06/09 was listed to allow Resident #5 enough time to feed his/herself. The potential for aspiration due to impaired swallowing was dated 04/06/09 with the goal of not aspirating by gagging with food intake. The problem of impaired breathing was identified on 04/06/09 with the intervention date 04/06/09 as keeping Resident #5 upright for at least thirty (30) minutes after eating. The potential of an infection was identified with an approach dated 04/06/09 to observe Resident #5 for a loss of appetite. Intervention dated 08/25/10 was to have food placed in individual dishes. An entry on the care plan noted that on 08/13/12 Resident #5 became</p>	F 280		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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F 280	<p>Continued From page 19</p> <p>NPO due to a refusal to swallow food. The care plan had not been updated to reflect the status of Resident #5 being NPO.</p> <p>Interview, on 01/08/13 at 12:10 PM, with Certified Nursing Assltant (CNA) #5 revealed Resident #5 was NPO. Resident #5 received no oral food.</p> <p>Interview, on 01/09/13 at 9:30 AM, with CNA #6 revealed Resident #5 never ate oral food.</p> <p>Interview, on 01/09/13 at 11:40 AM, with the Dietician revealed she had updated the care plan specific to her department on 12/27/12, noting the resident was NPO. She revealed she independently updated the care plan and it was not through the interdisciplinary team (IDT). She stated if another part of the care plan says Resident #5 eats from individual dishes, it was not updated.</p> <p>4. Observation of Resident #6, on 01/08/13 at 8:40 AM, revealed the resident in bed in his/her room. A high back wheelchair was present with tippers on the back. The bed was against the wall and a fall mat was on the floor beside the bed. The same observation was made at 2:30 PM.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident on 10/12/07 with diagnoses of Cerebral Degeneration, Hypertension, Arthropathy, Parkinson's and Abnormal Weight Loss. The facility completed a quarterly MDS assessment</p>	F 280		

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F 280	<p>Continued From page 20 on 10/30/12 which revealed Resident #6 was always Incontinent of bowel and bladder.</p> <p>Review of the care plan for Resident #6 revealed a problem with routine care needs dated 10/12/07. An approach listed was to toilet upon rising, before and after meals, at bedtime and as needed. In addition, the care plan noted an approach of a bladder training program. The CNA was to chart the number of times Resident #6 was continent and the number of times Resident #6 was incontinent under the bladder training program. The initiation date for the bladder training program was 08/12/08.</p> <p>Interview, on 01/09/13 at 9:30 PM, with Certified Nursing Asslstant (CNA) #6 revealed resident #6 was unable to tell staff when he/she needed to void. She revealed there was no charting for a bladder training program for Resident #6.</p> <p>Interview, on 01/09/13 at 3:50 PM, with CNA #7 revealed Resident #6 used adult briefs and was not on a bladder training program. In addition, she revealed her assignment sheet for Resident #6 said "incontinent", not toileting program.</p> <p>Interview, on 01/09/13 at 3:50 PM, with Licensed Practical Nurse (LPN) #3 revealed Resident #6 was not on a bladder training program. She revealed it was the responsibility of the Unit Manager to update the care plans.</p>	F 280		
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F 280	<p>Continued From page 21</p> <p>Interview, on 01/09/13 at 3:52 PM, with Unit Manager LPN #4 revealed she was not responsible to update the care plans. She revealed everyone was responsible to update the care plan as events occurred. She stated the care plans were reviewed during the morning meetings and the MDS staff was responsible for the accuracy of the care plan.</p> <p>Interview, on 01/09/13 at 3:40 PM, with MDS Nurse #1 revealed the other MDS nurse and she were responsible to update the care plan with the MDS assessment. She revealed if changes occurred, they (MDS) may update the care plan between MDS assessments. When an order was written, the change should go in the care plan section, she continued, and the person making a change in the resident's plan of care should update the care plan. She revealed the objective of the IDT was to make sure the care plan was being followed through each discipline. She revealed the importance of the IDT was so that one discipline was not doing something different to counteract the other.</p> <p>Interview, on 01/09/13 at 3:55 PM, with the Director of Nursing (DON) revealed a change in status for the resident, not just a physician's order, would create an update for the resident on their care plan using a three (3) part form. She revealed the CNA assignment sheets would be updated with the update of the resident's care plan. She stated the monitoring of the care plans was done by the IDT. She revealed the IDT go through the care plan during that resident's care plan meeting and changes were immediately</p>	F 280		

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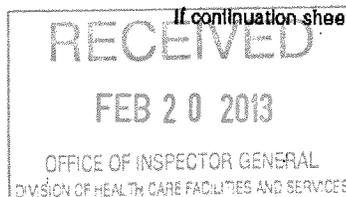
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<p>F 280</p> <p>F 329 SS=D</p>	<p>Continued From page 22 updated on the care plan. However, as evidenced by Resident #5 being fed through a gastric tube and Resident #6 not on a bladder training program as noted on the care plans, the care plans were not updated.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to</p>	<p>F 280</p> <p>F 329</p>	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F329 Drug Regimen free From Unnecessary Drugs 2/18/13</p> <p>It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to review the drugs of each resident at the Interdisciplinary Team meeting.</p> <p>Resident #2 went to the hospital on 01/13/2013 and was re-admitted back on 01/15/2013. Resident admitted with low dose of Seroquel. Tabler Group evaluated and has decreased Seroquel dosage. This was completed on 01/22/2013.</p> <p>IDT team meeting held and all residents on psychoactive medications were assessed for appropriate diagnosis, and appropriate gradual dose reductions. This was completed on 01/19/2013. All resident identified to have a need for a GDR were evaluated by Tabler Group Psychiatric services and orders received. This was completed on 01/22/2013.</p>	
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F 329	<p>Continued From page 23</p> <p>ensure one (1) of sixteen (16) sampled residents and eight (8) unsampled residents were free from unnecessary drugs. The facility placed Resident #2 on an antipsychotic medication without a gradual dose reduction attempted and no documented evidence why a reduction may be contraindicated. The record revealed the resident exhibited no behaviors that would indicate the use of the antipsychotic medication.</p> <p>The findings include:</p> <p>A facility policy related to behaviors and the use of antipsychotic medications was requested during the survey; however, the facility failed to provide a specific policy.</p> <p>Observation of Resident #2, on 01/08/13 at 8:15 AM, 11:00 AM, 12:30 PM, 3:15 PM, and 4:00 PM revealed the resident was in bed either sleeping or watching television. Interview with the resident during the 3:15 PM observation revealed the resident was experiencing throat pain and the nurse had given him/her pain medication.</p> <p>Review of the most current quarterly assessment, dated 12/11/12, revealed no behaviors or mood were observed during the assessment period. The facility assessed the resident to have no cognition impairment.</p> <p>Review of the clinical record revealed the facility admitted Resident #2 on 10/04/11 with the following diagnoses: Malignant Neoplasm of the oral and nasal cavities; Diabetes; Hypertension; Atrial-Fib; Supraventricular Tachycardia (SVT) (fast heart rate); Osteoarthritis; Acute Renal Failure; and Neuropathy. Review of the admission</p>	F 329	<p>Monthly reviews of GDR will be held with the IDT at risk group. Residents will be reviewed for GDR and recommendations made to Tabler Group or Medical Director.</p> <p>Education completed on Federal Regulation F 329 Drug Regimen is Free From Unnecessary Drugs with all licensed staff and Tabler Psychiatric Group on 01/19/2013. This was completed by the SDC and education was verified using testing and written education sources to determine licensed staff competency. This was completed on 01/19/2013.</p> <p>Education completed on Federal Regulation F 329 Drug Regimen is Free From Unnecessary Drugs will all staff and Tabler Psychiatric Group on 01/19/2013 by SDC and DON. The DON and ED addressed this issue with the Medical Director on 2/12/13</p> <p>IDT will make sure that all GDR's are appropriately addressed with Tabler Psychiatric Group, if unable to address with Tabler, address with the medical director.</p> <p>The Director of Nursing and/or Clinical Case Manager will monitor through record review (physician orders) and report review (Drug Regimen Review) monthly for twelve months at the Performance Improvement meeting to assure residents do not receive unnecessary drugs. The Executive Director is responsible for overall compliance.</p> <p>IDT will make sure that all GDRs are appropriately addressed with Tabler Psychiatric Group, if unable to address with Tabler, address with the medical director.</p>	
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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F 329	<p>Continued From page 24</p> <p>Minimum Data Set (MDS) assessment, dated 10/11/11, revealed the resident did not receive any psychotropic medications. The facility assessed the resident to have no cognition impairment with a Brief Interview Mental Status (BIMS) score of 15. The resident is 71 years old.</p> <p>Continued review of the clinical record revealed on 02/23/12, a contract Psychiatric Service came to the nursing facility and conducted an evaluation of the resident's mood and behaviors. The assessment revealed the resident reported anxiety regarding a recent biopsy and impending visit to the oncologist to obtain the results. The resident also reported insomnia. The Psychiatric Nurse Practitioner ordered Seroquel 50 mg, one at bedtime, for depression, anxiety, and insomnia. The assessment noted no behavior disturbances. On 03/05/12, the resident was seen by the same Nurse Practitioner and the resident reported the Seroquel 50 mg had been stopped due to a pharmacy consult report indicating a potential interaction between the Seroquel and Amiodarone (drug used to treat SVT). The Pharmacy was called and Seroquel 50 mg was restarted on 03/15/12. The resident was seen by the Psych services on 04/12/12 without any medication changes. Review of the most recent visit conducted on 01/03/13 revealed the same diagnoses of Major Depression, Anxiety, and Insomnia. The resident remained on Trazodone 25 mg and Seroquel 50 mg at bedtime. The resident's evaluation revealed the resident sitting in their room eating. The report revealed the resident was smiling and was more engaged in conversation. The Nurse Practitioner (NP) wrote no medication changes, "will hold on course for stability and consider GDR Seroquel next visit if</p>	F 329		
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F 329	<p>Continued From page 25 stable."</p> <p>Review of the Medication Administration Record (MAR) for January 2013 revealed the resident received Seroquel 50 mg every night for depression/anxiety. Review of the Behavior monitoring sheets from February 2012 through January 2013 revealed no documented behaviors. Review of the comprehensive care plan, dated 01/08/13, revealed a care plan was developed for drug related side effects regarding the use of Trazodone for insomnia on 08/08/12. However, the care plan was not revised to reflect the use of the medication Seroquel.</p> <p>Interview with RN #1, on 01/10/13 at 8:15 AM, revealed the staff nurse should monitor for medication side effects but there was not a place on the MAR to documented that information.</p> <p>Interview with the Director of Nursing (DON), on 01/10/13 at 9:15 AM, revealed she was responsible for monitoring psychotropic medications for Gradual Dose Reduction (GDR). When asked how the facility monitored medications for side effects or adverse effects she stated the nurse would monitor but did not document on the MAR. She indicated Psych medications were to be monitored for side effects by all staff but the certified nursing assistants (CNA) would have completed the behavior sheets. She indicated the residents who receive psychotropic medications are discussed during the weekly at risk meetings. She stated residents' behaviors are discussed and the committee members (that include a pharmacy representative and Nurse Practitioner at times) would consider whether the medication should be continued,</p>	F 329		
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F 329	<p>Continued From page 26</p> <p>reduced, or discontinued. She stated the Interdiscipline team (IDT) did not attend those meetings. The DON revealed the last at risk meeting was conducted on 12/12/12. She stated due to the holidays, some of the meetings had been missed.</p> <p>Continued Interview with the DON revealed she had approached the Nurse Practitioner to consider a GDR for Seroquel that Resident #2 was receiving; however, the Nurse Practitioner refused. When asked if the Nurse Practitioner proved a clinical rationale for continuing the antipsychotic medication without attempting a GDR, she acknowledged there was not and she stated there had not been a GDR attempted. She stated the resident did not exhibit behaviors, only anxiety.</p> <p>Interview with the Nurse Practitioner, on 01/10/13 at 1:05 PM, revealed the resident exhibited anxiety regarding the cancer and she felt the resident needed the medication. She stated the resident told her anti-anxiety medications had not worked in the past but he/she had taken Seroquel before and it helped the resident to sleep. She stated the resident did not exhibit any type of behaviors that would indicate antipsychotic medication use and did not have a diagnosis to support. She confirmed the DON had approached her regarding GDR and she should have attempted but she did not. She said she was considering a reduction on the next visit, but should have already attempted a GDR because there were no contraindications.</p> <p>Review of a pharmacy drug regimen consultation reports for March 2012 through December 2012,</p>	F 329		
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