PRINTED: 08/10/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185089		R-C 07/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	550 HIGH ST. BOWLING GREEN, KY 42101

RECEIVED AUG 2012 OFFICE OF INSPECTOR GENERAL

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS On 07/26-27/12, an onsite revisit to the abbreviated survey (07/12/12) was conducted which determined Immediate Jeopardy (IJ) had been removed at F-282, F-333, and F-514, on 07/21/12, as alleged in the acceptable Allegation of Compliance (AoC), received on 07/23/12. While the IJ was removed at F-282, F-333, and F-514, continued non-compliance remained as follows: F-282, F-333, and F-514 at a S/S of a "D". The facility's Performance Improvement Committee had not completed staff monitoring, analysis of information, nor had the opportunity to develop and implement a plan to ensure correction of the all deficient practice to prevent non-compliance recurrence. Furthermore, the State Agency had not received the facility's plan of correction for the 07/12/12 abbreviated survey. The non-IJ deficiencies, F-279 and F-224 cited during the abbreviated survey were not reviewed for compliance as the facility had not submitted a Plan of Correction (POC). Therefore, the deficiencies detailed on this statement of deficiencies for the revisit on 07/26-27/12 include F-279 and F-224 deficiencies identified on the abbreviated survey, dated 07/12/12.	{F 000}	*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.*	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224	F-224 1) Resident #2 no longer resides at the facility. Resident #3s care plan was revised on 07/02/12 by the Assistant Director of Nursing (ADNS) with appropriate interventions in place to observe for potential psychosocial and the C.N.A. assignment sheet updated accordingly. 2) The Director of Nursing(DNS)/or Assistant Director of Nursing (ADNS)/or Unit Managers (Ums)/or Social Services Directors (SSD) completed an audit on 08/02/12 of all facility resident's medical record and behavior logs for resident's displaying high risk behaviors that may affect others in the past 60 days and address accordingly through update of the resident's care plan with interventions to attempt to manage and prevent the resident from displaying sexually inappropriate behavior and interventions have been placed on the Certified Nurse Aid (C.N.A.) assignment sheet accordingly.	08/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] M.S.; B.S.; LNHA — TITLE: Administrator — (X6) DATE: 8/16/12

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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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW		STREET ADDRESS, CITY, STATE, ZIP CODE 650 HIGH ST. BOWLING GREEN, KY 42101	

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F 224	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies/procedures, it was determined the facility failed to ensure each resident was free from abuse for one resident (#3), in the selected sample of fifteen residents. The facility failed to implement policies and procedures that prohibited abuse. The facility failed to initiate effective interventions in order to manage Resident #2's inappropriate behaviors towards staff in an effort to prevent potential abuse of residents within the facility. The facility was knowledgeable of Resident #2's history of inappropriate behaviors towards staff in November 2011 and since readmission in March 2012; however, could provide no evidence of effective interventions implemented to address the behavior and to prevent potential abuse towards residents of the facility. On 06/30/12, a housekeeper observed Resident #2 touching Resident #3 on the breasts and between the legs. The housekeeper walked away without immediately intervening and reporting. A few minutes later, another CNA observed Resident #2 touching Resident #3 between the legs in the groin area and intervened, separating the residents and removing Resident #2 away from Resident #3 and reported to the nurse. Findings include: A review of the facility's "Abuse" policy, dated 10/11/11, revealed: Verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the patient as well as mistreatment, neglect, and misappropriation of patient property	F 224	*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.* 3) The Staff Development Coordinator (SDC)/DNS/ADNS/UM/Weekend Supervisor/Licensed Nurse conducted in-service beginning on 07/02/12 and completed on 08/11/12 with the facility staff on the Abuse Policy with an emphasis on the prevention, intervention, and reporting components. The SDC will include information on the Abuse Policy with an emphasis on the prevention, intervention, and reporting components in the orientation of new personnel. 4) The Administrator/or DNS/or ADNS/or UM/or SSD will monitor through record review at least monthly for three months, then quarterly, to assure all components of the Abuse Policy are fully implemented. The Administrator is responsible for overall compliance.	

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F 224	Continued From page 2 are strictly prohibited. All alleged violation involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including state survey and certification agency) Additionally, #11. Patients, with a personal history that renders them at risk for abusing other patients, are identified through: a. Interviews with the family b. Chart review c. Behavior Monitoring logs d. MDS-Mood Behavior Answers. Intervention strategies are developed to prevent and/or reduce occurrences, changes that would trigger abusive behavior are monitored, and interventions are reassessed on a regular basis. A review of the facility's Assessing Risk of or Exhibition of Challenging Behaviors(610610)" policy, dated 04/28/11, revealed: Rationale; Patients who exhibit behaviors that decrease their physical and psychosocial well-being and/or are dangerous for themselves or others are identified. The interdisciplinary team addresses patient behaviors in the patient's comprehensive plan of care. Procedure; 2. Develop care plan interventions to reduce and or eliminate the cause of behavioral symptoms. 9. Evaluate patient progress in decreasing or eliminating behavioral symptoms. Documentation Guidelines; 1. Document assessments for behavioral symptoms of potential for behavioral symptoms in the patient's medical record and care plan. 4. Update care plan, as necessary 8. Document patient's risk for future events of the same and update care plan.	F 224		

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F 224	Continued From page 3 A review of the facility's "Resident Exhibiting Challenging Behaviors (51005)" policy, dated 06/30/06, revealed: Rationale; A resident exhibiting behavior symptom in intervened with measures that reduce and/or eliminates behavior episodes while protecting the resident and/or others from harm. 9. Record the behavior(s) exhibited, interventions tried but unsuccessful, and/or successful interventions used on behavior monitoring log or similar tracking device. 10. Update the resident's care plan, as needed. Resident #2 was originally admitted to the facility on 11/02/11. Review of the Interim Care Plan, dated 11/02/11, indicated no behaviors. An interview, on 07/10/12 at 10:30 AM with RN #2, revealed she was aware of Resident #2's history of inappropriate behavior when he/she was first admitted to the facility in November 2011. Resident #2 came from a community where she was familiar with his/her inappropriate behavior and RN #2 was not comfortable being around him/her and requested she have no work assignments that included Resident #2. RN #2 had informed the Director of Nursing (DON) of Resident #2's history of inappropriate behaviors when he/she was admitted in November 2011 and arrangements were made to ensure she was not assigned to provide care for Resident #2. The Behavior Monitor for 11/11 revealed documentation, dated 11/05/11, of "Resident asked to kiss staff member" and was told that was an inappropriate question. Review of a Nursing Note, dated 11/12/11 at 4:00 PM, revealed "Resident behaving inappropriately (sexually) toward staff, attempting to touch staff member's breasts, requesting to kiss staff	F 224		

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F 224	Continued From page 4 member". The facility discharged as per the resident's request, to another facility on 11/18/11. On 03/14/12, the facility readmitted Resident #2 to the facility with diagnoses which included Depressive Disorder, Diabetes Mellitus and Systolic Heart Failure. A Minimum Data Set (MDS) quarterly assessment, dated 05/30/12, revealed the facility had assessed the resident with no cognitive impairment and the resident was totally independent with activities of daily living other than supervision and set up for meals. Resident #2 utilized a wheel chair for mobility due to choice and was ambulatory. Review of the Behavior Monitor, dated 04/12, revealed, on 04/09/12, Resident #2 told another resident that her husband died and when that resident left screaming and crying had laughed and carried on with his/her daily stroll. On 04/13/12, the Behavior monitor revealed "Resident has been calling staff member sexy and attempted to touch inappropriately and was told to stop." Review of a Psychiatric Progress Note, dated 04/19/12, revealed documentation "Has been sexually inappropriate at times". Psychiatric Progress Note, dated 06/07/12, revealed has been sexually inappropriate. Resident #2 transferred to the hospital for heart surgery on 06/12/12. He/she returned to the facility on 06/24/12. Review of Behavior Monitor, dated 06/12, revealed, on 06/26/12, Resident #2 was making sexual remarks to staff. Continued interview, on 07/10/12 at 10:30 AM, with RN #2, revealed the DON and ADON were	F 224		

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F 224	Continued From page 5 told again of RN #2's concern of Resident #2's behavior when he/she returned from the hospital on 06/24/12. RN #2 also revealed since Resident #2 returned from the hospital (06/24/12), she was aware of inappropriate behavior Resident #2 had toward a staff member. The staff member was positioned with little space between Resident #2 and herself and Resident #2 motioned as if he/she was licking the staff on the breast. This was not documented and should have been. RN #2 informed Social Worker #2, and the Social Worker talked to Resident #2, but RN #2 did not know what happened after that. An interview, conducted on 07/06/12 at 9:00 AM, with CNA #2 revealed Resident #2 had always made inappropriate comments and was "really vulgar and liked breasts and butts". She had not heard him/her be inappropriate to a resident before and stated "We as staff get used to it". An interview, conducted on 07/05/12 at 2:00 PM, with CNA #1 revealed Resident #2 has talked about her breasts and oral sex and told her a resident (#3) had given him/her oral sex. Resident #2 stated he/she had "molested a girl" and "she gave me a blow job" and CNA #1 reported that to a nurse (unknown) and the DON. CNA #1 stated Resident #2 made her uncomfortable to be around. An interview with RN #5, on 07/06/12 at 10:00 AM, revealed staff had made her aware of Resident #2's inappropriate behaviors and that he/she had been inappropriate most days. An Interview with RN #3, on 07/10/12 at 3:00 PM, revealed Resident #2 had behaviors (couldn't	F 224		

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F 224	Continued From page 6 recall exact dates) of looking down her blouse while accuchecks were being performed and had pinched her on the buttocks and was told that was inappropriate. A week or so later Resident #2 pinched her on the buttocks again while on the A Hall and was witnessed by others. Resident #2 was told again that was inappropriate but RN #3 did not report or document the behaviors anywhere. Review of the facility summary with an incident date of 06/30/12 revealed Resident #2 was observed by housekeeping staff that was going from D Hall to B Hall, to be touching Resident #3 on the breasts. A CNA observed Resident #2 sitting beside Resident #3 in the North Lounge and saw Resident #2 pick up the sheet that was across the lap of Resident #3 and reach into his/her groin area. The residents were separated. Resident #3 was assessed with no red areas noted. Resident #2 was placed on 1:1 (one to one) supervision. The Police Department was notified. An interview, conducted on 07/07/12 at 6:20 PM, with Housekeeper #1 revealed, on 06/30/12, she was working and had observed Resident #2 touching Resident #3 on the breasts as they sat in the lobby area. Housekeeper #1 revealed after she saw Resident #2 touch Resident #3 on the breasts she continued on her way to the linen room. She didn't do anything to stop Resident #2 nor did she report immediately what she had observed to the nurse. A minute or so later, a CNA saw Resident #2 touching the resident again. She stated she received a written warning disciplinary action because she walked away without intervening and reporting. Housekeeper #1 stated "I should have reported immediately". The housekeeper	F 224		

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F 224	Continued From page 7 received inservicing about the facility abuse policy on 07/03/12. A Psychiatric Progress Note, dated 07/05/12 (five days after Resident #2 inappropriately touched Resident #3), revealed documentation to include: "Has been sexually inappropriate, is aware of behavior, says [he/she] is sorry, no reason given for behavior". An interview was attempted with Resident #3, on 07/05/12 at 1:10 PM; however, due to the resident's impaired cognition; he/she could not provide any information related to the incident. An interview was conducted on 07/05/12 at 3:25 PM with Resident #2. The resident revealed he/she had his/her hand in the wrong area on Resident #3 and that was when he/she was "caught". He/she revealed he/she was "listening to my thing instead of my brain, that was the wrong thing to do, I need to listen to my brain". Resident #2 stated he/she had never gotten into trouble where he/she lived before and that he/she "probably could have paid money for it". Continued interview with RN #5, on 07/06/12, revealed while she was aware of Resident #2's inappropriate behaviors occurring most days, she did not recall documenting behaviors or adding an intervention for inappropriate behavior and thought Social Services did that. An interview, conducted on 07/06/12 at 10:30 AM, with the Social Service Director revealed Resident #2 had behaviors of making sexual comments toward staff and felt the behaviors were managed through the care plan.	F 224		

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F 224	Continued From page 8 An interview, conducted on 07/06/12 at 11:00 AM, with Social Worker #2 revealed she had not witnessed any inappropriate behavior from Resident #2 but found out about the incident that occurred on 06/30/12 on 07/02/12. She had spoken with Resident #2 about the behavior and stated "[Resident #2] knew what [he/she] was doing and wanted to apologize to Resident #3 but was not allowed to have further contact". Social Worker #2 stated Resident #2 understood what he/she did and did not give a reason for the behavior. The resident knew it was wrong and did it anyway. An interview with the Psychiatric Physician, on 07/11/12 at 2:40 PM, revealed the facility had informed him of the incident (date unclear) and he did an emergency visit with Resident #2 on 07/05/12. The Physician was aware of Resident #2's behaviors as the nurses and social workers meet with him before he sees a resident. He had been told about verbal sexual comments the resident had made but was not aware of Resident #2 acting out sexually with a patient before 06/30/12. Buspar five milligrams three times a day was prescribed but the Physician stated he did not know what medicine he could prescribe to prevent sexual behavior. He stated "You have to be cautious, once in a while they act out, you don't always know who will act out, everybody can't be put on one to one supervision and safety of patients is a main concern". On 07/09/12 at 11:05 AM, an interview with the Director of Nursing (DON) revealed she was only aware Resident #2 made comments to staff about their appearance. No staff had ever told	F 224		

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F 224	Continued From page 9 her Resident #2 had touched any resident. She was not aware Resident #2 had acted out inappropriately by pinching staff on the buttocks. She would expect the staff to report and document those incidents as that was part of the facility policy. The DON stated she "Never had any idea Resident #2 would look at residents" and "We should always provide for helpless residents". The facility was unable to provide documented evidence that they initiated their policies and procedures related to addressing Resident #2's sexually inappropriate behavior in order to prevent Resident abuse despite having the knowledge of his/her behaviors and staff feeling uncomfortable with those behaviors.	F 224	*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.*	
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. 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).	F 279	F-279 1)Resident #2 no longer resides at the facility. Resident #3s care plan was revised on 07/02/12 by the Assistant Director of Nursing (ADNS) with appropriate interventions in place to observe for potential psychosocial and the C.N.A. assignment sheet updated accordingly.	08/13/12

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F 279	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies/procedures, it was determined the facility failed to review and revise the resident care plan for two residents (#2 and #3), in the selected sample of fifteen residents. The facility failed to follow their policies and procedures related to care planning and assessing residents with challenging behaviors. The facility was knowledgeable of Resident #2's history of sexually inappropriate behaviors towards staff. On 06/30/12, Resident #2 was observed by staff, touching Resident #3 on the breast and groin. Resident #2 was placed on one to one supervision. A review of the care plans revealed the facility failed to address/update the care plans for both residents. Findings include: A review of the facility policy, titled ASSESSING RISK OF OR EXHIBITION OF CHALLENGING BEHAVIORS (610610), dated 04/28/11, revealed: Rationale; Patients who exhibit behaviors that decrease their physical and psychosocial well-being and/or are dangerous for themselves or others are identified. The interdisciplinary team addresses patient behaviors in the patient's comprehensive plan of care. Procedure; 2. Develop care plan interventions to reduce and or eliminate the cause of behavioral symptoms. 9. Evaluate patient progress in decreasing or eliminating behavioral symptoms. Documentation Guidelines; 1. Document assessments for	F 279	*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.* 2) An audit was completed on 08/02/12 by the DNS/orADNS/orSSD/orUM on all facility residents for behavioral problems to ensure their care plan and CNA Assignment sheets accurately reflects their problems and appropriate interventions to address. 3) The DDCO/or SDC/or DNS/or ADNS inserviced the Unit Managers, Weekend Supervisor, SSD and Reflections Program Director on 8/7/12 regarding updating the resident's comprehensive care plans and the CNA Assignment when a new behavior is identified. The DNS/or ADNS/or UM will perform care plan and CNA assignment sheet audits for accuracy when a new behavior is identified Monday – Friday x 4 weeks, then randomly thereafter x 3 months to ensure compliance. 4) The findings will be discussed at the monthly PI meeting x 3 months, then quarterly thereafter until compliance is met. The Administrator and/or DNS are responsible to ensure compliance with this standard.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED R-C 07/27/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW		STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 behavioral symptoms of potential for behavioral symptoms in the patient's medical record and care plan. 4. Update care plan, as necessary 8. Document patient's risk for future events of the same and update care plan. A review of the facility policy, titled RESIDENT EXHIBITING CHALLENGING BEHAVIORS (51005) dated 06/30/06, revealed: Rationale; A resident exhibiting behavior symptom in intervened with measures that reduce and/or eliminates behavior episodes while protecting the resident and/or others from harm. 9. Record the behavior(s) exhibited, interventions tried but unsuccessful, and/or successful interventions used on behavior monitoring log or similar tracking device. #10 update the resident's care plan, as needed. 1. Resident #2 was originally admitted to the facility on 11/02/11 and had diagnoses to include Depressive Disorder, Diabetes Mellitus and Systolic Heart Failure. A review of Resident #2's record revealed an Interim Care plan, dated 11/02/11, that indicated no behaviors. The Behavior Monitor for 11/11 revealed documentation, dated 11/05/11, of "Resident asked to kiss staff member" and was told that was an inappropriate question. Review of a Nursing Note, dated 11/12/11 at 4:00 PM, revealed "Resident behaving inappropriately (sexually) toward staff, attempting to touch staff member's breasts, requesting to kiss staff member". The resident was discharged per his/her request on 11/18/12 to another facility. On 03/14/12, the facility readmitted Resident #2 having knowledge of the resident's history of sexually inappropriate behavior. However,	F 279		

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F 279	Continued From page 12 review of the care plan upon readmission showed no evidence of interventions to address the resident's inappropriate sexual behaviors. Review of the Behavior Monitor, dated 04/12, revealed, on 04/13/12, "Resident had been calling staff member sexy and attempted to touch inappropriately and was told to stop". Review of the care plan revealed no interventions were developed or implemented to address the resident's behaviors. Review of a Psychiatric Progress Note, dated 04/19/12, revealed physician documentation "Has been sexually inappropriate at times". A Minimum Data Set (MDS) quarterly assessment, dated 05/30/12, revealed the facility had assessed the resident with no cognitive impairment and the resident was totally independent with activities of daily living other than supervision and set up for meals. Resident #2 utilized a wheel chair for mobility due to choice and was ambulatory. Psychiatric Progress Note, dated 06/07/12, revealed "Has been sexually inappropriate". Review of a facility summary of an incident, dated of 06/30/12, revealed Housekeeping staff observed Resident #2 touching Resident #3 on the breasts. A CNA observed Resident #2 sitting beside Resident #3 in the North Lounge and saw Resident #2 pick up the sheet that was across the lap of Resident #3 and reach into his/her groin area. The residents were separated. Resident #3 was assessed with no red areas noted. Resident #2 was placed on 1:1 (one to one) supervision. The Police Department was notified. Review of the 07/12 Behavior sheet revealed undated documentation the resident offered money from his/her Bible to a staff member to	F 279		

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F 279	Continued From page 13 show him/her the staff's tattoo and wanted to tell what he/she would like to do with the staff sexually. A review of Comprehensive Care Plan provided on 07/05/12, dated 07/03/12, revealed Problem Description "I Have Behavior/Mood Patterns;" however, the Comprehensive Care Plan did not have any behaviors documented in the "Related To column" and there were no goals or interventions specific to address sexually inappropriate behaviors. A Psychiatric Progress Note, dated 07/05/12 (five days after Resident #2 inappropriately touched Resident #3 on 06/30/12), revealed documentation to include: "Has been sexually inappropriate, is aware of behavior, says he/she is sorry, no reason given for behavior". On 07/06/12 at 9:00 AM, an interview with CNA #2 revealed Resident #2 had always made inappropriate comments and was "really vulgar and liked breasts and butts". The CNA stated "We as staff get used to it". An interview with RN #5, on 07/06/12 at 10:00 AM, revealed she was aware of Resident #2's inappropriate behavior and he/she was inappropriate most days. RN #5 did not recall adding an intervention for inappropriate behavior and thought Social Services did. On 07/06/12 at 10:30 AM, an interview with the Social Service Director revealed Resident #2 had behaviors of making sexual comments toward staff and felt the behaviors were managed through the care plan. An interview with Social Worker #2, on 07/06/12	F 279		

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F 279	Continued From page 14 at 11:00 AM, revealed, on 07/02/12, she had learned of an incident where Resident #2 had inappropriately touched Resident #3 on 06/30/12. She was aware of Resident #2 being sexually inappropriate with staff before her employment (one month ago) at the facility. She spoke with Resident #2 about the behavior and said "He/she knew what he/she was doing and wanted to apologize to Resident #3 but was not allowed to have further contact". Social Worker #2 stated Resident #2 understood what he/she did and did not give a reason for the behavior. The resident knew it was wrong and did it anyway. She stated and confirmed that she had not added interventions to address inappropriate sexual behavior to the resident's care plan until after the incident occurred on 06/30/12. She verified that the Behavior care plan, prior to 06/30/12, did not address sexually inappropriate behaviors. Furthermore, review of the care plan on 07/05/12, dated 06/29/12, revealed no care plan interventions had been detailed for inappropriate sexual behavior. 2. Resident #3 was admitted to the facility on 07/05/11 with diagnoses to include Encephalopathy, Chronic Respiratory Failure, Delirium, Buerger's Disease and Seizures. Review of an MDS quarterly assessment, dated 05/03/12, revealed the facility assessed the resident cognitively impaired and required extensive to total assistance with activities of daily living and was bed or chair bound. Review of Nurse's Notes, dated 06/30/12 at 1:30 PM, revealed documentation as "Resident was touched by a [male/female] resident, was sitting in North lounge, skin assessment completed".	F 279		

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F 279	Continued From page 15 Review of Physician Communication and Progress Note, dated 06/30/12, revealed "Resident touched by [male/female] resident, skin assessment performed, family notified and does not want to press charges". Review of a facility summary with an incident occurring on 06/30/12 revealed a housekeeper observed Resident #2 touching Resident #3 on the breasts. A CNA observed Resident #2 sitting beside Resident #3 in the North Lounge and saw Resident #2 pick up the sheet that was across the lap of Resident #3 and reach into his/her groin area. The residents were separated. Resident #3 was assessed with no red areas noted. Resident #2 was placed on 1:1 supervision. The Police Department was notified. An interview with RN #3, on 07/08/12 at 12:36 PM, revealed she was with Resident #3 after the incident on 06/30/12. She stated Resident #3 had stated he/she felt sad. RN #3 observed Resident #3 having a sad facial expression. RN #3 stated this change in the resident's disposition lasted for an hour or so after the incident. A review of Resident #3's care plan, dated 05/12 revealed there was no update to include "at risk for potential psychosocial effects" related to the incident on 06/30/12, until 07/02/12. An interview with Social Worker #2 on, 07/06/12 at 11:00 AM revealed she would implement a care plan intervention when she was made aware of an incident. Social Worker #2 stated she found out about the incident on 07/02/12 and interventions were implemented; however, no	F 279		

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	185089	A. BUILDING _____ B. WING _____	R-C 07/27/2012

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KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	550 HIGH ST. BOWLING GREEN, KY 42101

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F 279	Continued From page 16 interventions were developed for three days.	F 279	*This Plan of Correction is the center's credible allegation of compliance.*	
{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.	{F 282}	*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.*	
	This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 07/11/12, had been removed related to implementation of resident care plans. However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and the facility had not had an opportunity to develop and implement a Plan of Correction (POC), related to implementation of resident care plans. Findings include: Review of the Acceptable Allegation of Compliance (AoC), dated 07/23/12, revealed the facility audited all in-house resident care plan interventions related to medications to ensure the interventions were appropriate and implemented in accordance with the care plan on 07/17/12. The Staff Development Coordinator and Director of Nursing Services initiated education with all Licensed Nurses and Certified Medication Technicians on Care Plan Implementation related		F-282 1). Resident #1 no longer resides at the facility. 2).On 4/29/12, the Director of Nursing conducted education with the Registered Nurse who incorrectly transcribed the physician order on 4/7/12. The education consisted of, but not limited to: clinical abbreviations, including the triangle symbol, which means change; Coumadin medication regimen, including appropriate use, administration and monitoring; physician order clarification; and critical thinking skills. On 7/20/12, the Director of Nursing conducted education with the Registered Nurse who incorrectly transcribed the physician order on 4/7/12. The education consisted of, but not limited to: all Kindred clinical abbreviations, to include symbols and acronyms.	08/13/12

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{F 282}	Continued From page 17 to medications which included the pre-printed and Care Plan Review and Revision. Review of the documented inservice which was provided to the Certified Medication Technicians revealed the education included appropriate and timely administration of medications as indicated, and as an intervention in the resident's plan of care and in accordance with Certified Medication Technician scope of practice. The Licensed Nurses were educated about the facility Procedure 61002 Initial Plan of Care. The procedure included, but was not limited to, developing an initial care plan within twenty-four hours of admission and addressed the resident's initial individual and immediate needs until the interdisciplinary team finalized the comprehensive care plan. The education also included Procedure 61005, Comprehensive Plan of Care, which addressed implementation of the care plan, appropriate and timely administration of medications as indicated. Utilization and review of a pre-printed care plan to ensure appropriate interventions were appropriate and implemented was addressed in the education. The education included revision of the care plan, as indicated, through utilization of the Care Plan Update form to reflect current status. The Care Plan Update form covered the problem, goal and intervention. Administration of medications in accordance with the physician orders was included in this education. Unit Managers and Registered Nurse Weekend Supervisors reviewed all new physician orders and care plan updates for transcription accuracy daily and implementation of medication	{F 282}	*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.* On July 17, 2012, Nursing Administration to consist of Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, Minimum Data Set Coordinators, Registered Nurses and Licensed Practical Nurses audited all in-house resident care plan interventions related to medications to ensure the interventions are appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. Any medication intervention identified as not having been implemented was implemented immediately. 3). On July 17, 2012, the Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of Nursing Services, and/or Weekend Supervisor, initiated education with all Licensed Nurses and Certified Medication Technicians related to Care Plan Implementation related to medications, including "pre-printed" and on Care Plan Review and Revision. Education was complete on 8/9/12. The SDC will include information on Care Plan Implementation related to medications in the orientation of new personnel.	

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{F 282}	Continued From page 18 interventions. Audit findings were documented on a Medical Doctor Transcription audit and the Unit Manager and/or Weekend Supervisor dated and initialed the pink copy of the Physician Telephone Order sheet. All audit findings were being reviewed at the weekly Performance Improvement Committee. Interviews conducted with Medication Technicians and Licensed Nurses on 07/26-27/12 confirmed this education had been completed. Review of the documented inservices completed on 07/17/12, and interview with the RN Corporate Compliance Nurse on 07/27/12, revealed only one licensed staff had not received the inservice due to military service and that staff would receive the education upon return to the facility. An interview with the Administrator and Director of Nursing (DON) on 07/27/12 at 12:00 PM revealed the Staff Development Coordinator and Director of Nursing Services initiated education with all Licensed Nurses and Certified Medication Technicians on Care Plan Implementation related to medications which included the pre-printed and Care Plan Review and Revision. Administration of medications in accordance with the physician orders was included in this education. One staff remains to be inserviced. Unit Managers and Weekend Supervisors were auditing all physician orders and care plan updates daily and documented on a Medical Doctor Transcription audit and reviewed at the weekly Performance Improvement Committee. The PI Committee had met on 07/11/12 and 07/17/12, 07/20/12 to review the all audit findings; however, scheduled to continue to meet for three months and then	{F 282}	*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.* 4). The DNS /or ADNS /or UM /or WS will review all care plan updates Monday- Friday for implementation of medication interventions until deemed unnecessary as determined by the Performance Improvement Committee. All audit findings will be reviewed at the monthly Performance Improvement Committee x 3 months and then quarterly thereafter until deemed unnecessary. The Administrator and/or DNS are responsible to ensure compliance with this standard.	

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{F 282}	Continued From page 19 quarterly to evaluate their process to ensure compliance. Record review revealed the facility had not had an opportunity to complete their Performance Improvement Committee reviews of all audit findings to ensure compliance with the regulation would be achieved and sustained. Additionally, the facility had not submitted their plan of correction, related to this deficient practice, to the State Agency prior to the 07/27/12 visit.	{F 282}	*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.*	
(F 333) SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 07/11/12, had been removed related to transcription of physician's orders to the Medication Administration Record (MAR). However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and the facility had not had an opportunity to develop and implement a Plan of Correction (POC), related to transcription of physician's orders to the Medication Administration Record (MAR). Findings include:	{F 333}	F-333 1). Resident #1 no longer resides at the facility. 2). On 4/29/12, the Director of Nursing conducted education with the Registered Nurse who incorrectly transcribed the physician order on 4/7/12. The education consisted of, but not limited to: clinical abbreviations, including the triangle symbol, which means change; Coumadin medication regimen, including appropriate use, administration and monitoring; physician order clarification; and critical thinking skills. On 7/20/12, the Director of Nursing conducted education with the Registered Nurse who incorrectly transcribed the physician order on 4/7/12. The education consisted of, but not limited to: all Kindred clinical abbreviations, to include symbols and acronyms.	08/13/12

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{F 333}	Continued From page 20 Review of the acceptable Allegation of Compliance (AoC), dated 07/23/12, revealed, on 07/17/12, Nursing Administration consisted of the Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, Minimum Data Set Coordinators, Registered Nurses and Licensed Practical Nurses who audited all in-house residents from June 1, 2012, forward to ensure the orders were accurately transcribed to the Medication Administration Record (MAR) and that the dosage, frequency, and route of administration were appropriate. Individual physician's orders were compared with the resident's MAR to ensure orders were transcribed completely and accurately. If a medication variance was identified through the auditing process, the resident's attending physician and family were notified and the resident was placed on 72 hour condition change monitoring. Orders were also clarified with the resident's physician by the Unit Manager or Licensed Nurse. There were no transcription errors related to abbreviations, symbols, or acronyms identified. On 04/29/12, Registered Nurse (RN) #1, who incorrectly transcribed the physician's order on 04/07/12, was educated by the Director of Nursing related to clinical abbreviations, including the triangle symbol, which meant change, Coumadin medication regimen, including appropriate use, administration and monitoring, physician order clarification, and critical thinking skills. On 07/20/12, the Director of Nursing provided education to the RN who incorrectly transcribed the physician's order on 07/07/12. The education consisted of, but was not limited to all clinical abbreviations, including symbols and acronyms. Effective 07/20/12, the Director of	{F 333}	*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.* On July 11, 2012, Nursing Administration to consist of Director of Nursing Services, Assistant Director of Nursing, Unit Managers, Minimum Data Set Coordinators, and Registered Nurse Case Manager (CM), facility Registered Nurses and facility Licensed Practical Nurses reviewed all new physician orders for all in-house residents from June 1, 2012 forward to assure the orders were accurately transcribed to the Medication Administration Record and that the dosage, frequency, and route of administration were appropriate. The individual physician orders were then compared with the resident's Medication Administration and Treatment Records to assure that orders were transcribed completely and accurately. If a Medication Variance was identified through the auditing process, the resident's attending physician and family were notified by either the Unit Manager or facility Licensed Nurse and the resident was placed on 72 hour condition change monitoring. Orders were also clarified with the resident's physician as necessary by the Unit Manager or facility Licensed Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R-C 07/27/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW		STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 333}	Continued From page 21 Nursing, Assistant Director of Nursing and/or the Weekend Supervisor will provide direct supervision of the RN through observation and record review. Direct observation of transcription of physician's orders was conducted for this nurse. Also, a review of this RN's documentation was being completed prior to the end of each shift worked. The direct observation of the transcription of physician's orders was documented by the Director of Nursing, Assistant Director of Nursing, and/or the Weekend Supervisor. The documentation included the observer's initials, date, time, and name of the resident. The Executive Director and Director of Nursing will review the documentation weekly to identify any areas of improvement needed. The Director of Nursing and/or the Assistant Director of Nursing will review all physician's orders transcribed by this RN and validate transcription accuracy with the MAR. A review of documented education revealed all Licensed Nurses were educated related to the Medical Doctor's order transcription. All current facility licensed staff had been provided the education by 07/17/12 except for one that was active military and that nurse will have the education prior to return to the facility. The education consisted of facility, Procedure 62000 Physician's Orders, which included definition of a standing order, routine order, orders upon admission, treatment orders, as needed medication and treatment orders, all physician's orders and performance improvement. The education also included appropriate steps and timeliness of transcription of physician medication and treatment orders.	{F 333}	*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.* The audit revealed no transcription errors related to abbreviations, to include symbols and acronyms. 3) On July 11, 2012, the Registered Nurse Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of Nursing Services and/or Weekend Supervisor, initiated education with all Licensed Nurses related to Medical Doctor Order Transcription. Education was complete on 7/23/12. The SDC will include information related to Medical Doctor Order Transcription in the orientation of new personnel. On July 12, 2012, the Registered Nurse Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of Nursing Services and/or Weekend Supervisor, initiated education with all Licensed Nurses related to Medication Errors. On July 17, 2012 the Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of	

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{F 333}	Continued From page 22 Interview with RN #1, on 07/26/12 at 12:20 PM, revealed he had received education and training by the Director of Nursing related to transcribing physician's orders and he was being directly monitored by the Weekend Supervisor. Interviews on 07/26/12 and 07/27/12 with facility licensed staff revealed they had received education from facility administrative staff related to physician's order transcription including symbols. The education consisted of order accuracy, transcribing to the MAR or TAR and initialing the order as noted with date and time. Medication error education was provided related to the definition of medication error, significant medication error, error rate, drug adverse drug reaction, and the individual steps the licensed nurse was required to take for each. The interviews confirmed Unit Managers were double checking orders daily and initialing the pink copy of the orders. The Executive Director, the Director of Nursing and/or the Assistant Director of Nursing were validating the monitoring and evaluation of the Medical Doctor Transcription audits daily. Performance Improvement meetings were verified conducted on 07/11/12, 07/17/12 and 07/20/12. An interview with the Administrator and Director of Nursing (DON) on 07/27/12 at 12:00 PM revealed RN #1 was inserviced on clinical abbreviations, Coumadin medication regimen, physician order clarification and critical thinking skills. A review of this RN's documentation was being	{F 333}	*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.* Nursing Services and/or Weekend Supervisor, initiated education with all Certified Medication Technicians related to Medication Errors. Education was complete on 7/18/12. The SDC will include information Medication Errors in the orientation of new personnel. On July 20, 2012, the Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers and/or Weekend Supervisor initiated education with all Licensed Nurses related to Kindred clinical abbreviations, to include symbols and acronyms. Education was complete on 7/23/12. The SDC will include information related to Kindred clinical abbreviations, to include symbols and acronyms in the orientation of new personnel.	

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{F 333}	Continued From page 23 completed prior to the end of each shift worked. They stated that the facility was still in the process of conducting audits i.e. the Executive Director and Director of Nursing will review the documentation weekly to identify any areas of improvement needed and all physician orders will be reviewed for transcription accuracy daily. They revealed the PI Committee would continue to audit all findings for three months and then quarterly ongoing. Record review revealed the facility had not had an opportunity to complete their Performance Improvement Committee reviews of all audit findings to ensure compliance with the regulation would be achieved and sustained. Additionally, the facility had not submitted their plan of correction, related to this deficient practice, to the State Agency prior to the 07/27/12 visit.	{F 333}	*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.*	
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced	{F 514}	4) The Unit Managers and/or Registered Nurse Weekend Supervisor will review all new physician orders for transcription accuracy Monday – Friday and until deemed unnecessary as determined by the Performance Improvement Committee. Audit findings will be documented on a Medical Doctor Transcription audit. Any identified concerns will be corrected immediately by the Unit Manager and/or Registered Nurse Weekend Supervisor with appropriate follow-up with the licensed nurse. All audit findings will be reviewed at the monthly Performance Improvement Committee x 3 months and then quarterly thereafter until deemed unnecessary. The Administrator and/or DNS are responsible to ensure compliance with this standard. F-514 1). Resident #1 no longer resides at the facility.	08/13/12

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{F 514}	Continued From page 24 by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 07/11/12, had been removed related to accurate transcription of physician's orders to the Medication Administration Record (MAR). However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and the facility had not had an opportunity to develop and implement a Plan of Correction (POC), related to accurate transcription of physician's orders to the Medication Administration Record (MAR). Findings include: Review of the Acceptable Allegation of Compliance (AoC), dated 07/23/12, revealed on 07/17/12, Nursing Administration to consist of the Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, Minimum Data Set Coordinators, Registered Nurses and Licensed practical Nurses audited all in-house residents from June 1, 2012, forward to ensure the orders were accurately transcribed to the Medication Administration Record (MAR) and that the dosage, frequency, and route of administration were appropriate. Individual physician orders were compared with the resident's MAR to ensure orders were transcribed completely and accurately. If a medication variance was identified through the auditing process, the resident's attending physician and family were notified and the resident placed on 72 hour condition change monitoring. Orders were	{F 514}	*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.* 2). On 4/29/12, the Director of Nursing conducted education with the Registered Nurse who incorrectly transcribed the physician order on 4/7/12. The education consisted of, but not limited to: clinical abbreviations, including the triangle symbol, which means change; Coumadin medication regimen, including appropriate use, administration and monitoring; physician order clarification; and critical thinking skills. On 7/20/12, the Director of Nursing conducted education with the Registered Nurse who incorrectly transcribed the physician order on 4/7/12. The education consisted of, but not limited to: all Kindred clinical abbreviations, to include symbols and acronyms. On July 11, 2012, Nursing Administration to consist of Director of Nursing Services, Assistant Director of Nursing, Unit Managers, Minimum Data Set Coordinators, and Registered Nurse Case Manager (CM), facility Registered Nurses and facility	

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{F 514}	Continued From page 25 also clarified with the resident's physician by the Unit Manager or Licensed Nurse. There were no transcription errors related to abbreviations, symbols or acronyms identified. Registered Nurse (RN) #1, who had incorrectly transcribed a physician's order on 04/0712, was provided education by the Director of Nursing (DON) on 04/29/12 and on 07/20/12. The education included clinical abbreviations, including the triangle symbols which indicates change, Coumadin medication regimen and physician order clarification and critical thinking skills. A review of documented education revealed all Licensed Nurses were educated related to the Medical Doctor's order transcription, developing an initial care plan within 24 hours that addressed the resident's initial individual and immediate needs until the interdisciplinary team finalized the comprehensive care plan. The education included appropriate and timely administration of medications as indicated as an intervention in resident's plan of care. Also included in the education, was the utilization and review of pre-printed care plans to ensure interventions were appropriate and implemented as well as revision of the care plan, as indicated, through utilization of the Care Plan Update form which included the Problem, Goal and Intervention. Education related to definition of standing orders, routine orders, orders upon admission, treatment orders and performance improvement was provided. The education also included appropriate steps and timeliness of transcription of physician's medication and treatment orders. It was verified all facility licensed staff had been	{F 514}	*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.* Licensed Practical Nurses reviewed all new physician orders for all in-house residents from June 1, 2012 forward to assure the orders were accurately transcribed to the Medication Administration Record and that the dosage, frequency, and route of administration were appropriate. The individual physician orders were then compared with the resident's Medication Administration and Treatment Records to assure that orders were transcribed completely and accurately. If a Medication Variance was identified through the auditing process, the resident's attending physician and family were notified by either the Unit Manager or facility Licensed Nurse and the resident was placed on 72 hour condition change monitoring. Orders were also clarified with the resident's physician as necessary by the Unit Manager or facility Licensed Nurse. The audit revealed no transcription errors related to abbreviations, to include symbols and acronyms.	

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{F 514}	Continued From page 26 provided the education by 07/17/12. Interview with RN #1, on 07/26/12 at 12:20 PM, revealed he had received education and training by the Director of Nursing related to transcribing physician orders and he was being directly monitored by the Weekend Supervisor. Interviews on 07/26/12 and 07/27/12 with facility licensed staff revealed they had received education from facility administrative staff related to physician order transcription including symbols. The education had consisted of order accuracy, transcribing to the MAR or TAR and initialing the order as noted with date and time. Medication error education was provided related to the definition of medication error, significant medication error, error rate, drug adverse drug reaction, and the individual steps the licensed nurse was required to take for each. The interviews confirmed Unit Managers were double checking orders daily and initialing the pink copy of the orders. Unit Managers and /or Registered Nurse Weekend Supervisor were reviewing all new physician's orders and care plan updates for transcription accuracy daily. Audits were being documented on a Medical Doctor Transcription audit and the Unit Manager and/or Weekend Supervisor will date and initial the pink copy of the Physician's Order sheet. All audit findings will be reviewed at the weekly Performance Improvement Committee. The Executive Director, the Director of Nursing and the Assistant Director of nursing were validating the monitoring and evaluation of the	{F 514}	*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.* On July 17, 2012, Nursing Administration to consist of Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, Minimum Data Set Coordinators, Registered Nurses and Licensed Practical Nurses audited all in-house resident care plan interventions related to medications to ensure the interventions are appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. Any medication intervention identified as not having been implemented was implemented immediately. 3) On July 11, 2012, the Registered Nurse Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of Nursing Services and/or Weekend Supervisor, initiated education with all Licensed Nurses related to Medical Doctor Order Transcription. Education was complete on 7/23/12. The SDC will include information on Medical Doctor Order Transcription in the orientation of new personnel.	

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{F 514}	Continued From page 27 Medical Doctor Transcription audits daily. Performance Improvement meetings were verified conducted on 07/11/12, 07/17/12 and 07/20/12. An interview with the Administrator and Director of Nursing (DON) on 07/27/12 at 12:00 PM revealed Registered Nurse (RN) #1, who had incorrectly transcribed a physician's order on 04/0712, was provided education by the Director of Nursing (DON) on 04/29/12 and on 07/20/12. RN #1 was being directly monitored related to transcribing transcription orders. All licensed staff except one received inservicing related to transcribing physician orders. They revealed audits were still be conducted by Unit Managers and Weekend Supervisors related to all physician orders and care plan updates daily. All physician orders will continue to be reviewed for transcription accuracy daily and the PI Committee would continue to audit all findings for three months and then quarterly. Record review revealed the facility had not had an opportunity to complete their Performance Improvement Committee reviews of all audit findings to ensure compliance with the regulation would be achieved and sustained. Additionally, the facility had not submitted their plan of correction, related to this deficient practice, to the State Agency prior to the 07/27/12 visit.	{F 514}	*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.* On July 12, 2012, the Registered Nurse Staff Development Coordinator and/or designee, to consist of Director of Nursing Services, Assistant Director of Nursing Services and/or Weekend Supervisor, initiated education with all Licensed Nurses related to Medication Errors. On July 17, 2012 the Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of Nursing Services and/or Weekend Supervisor, initiated education with all Certified Medication Technicians related to Medication Errors. Education was complete on 7/18/12. The SDC will include information on Medication Errors in the orientation of new personnel. On July 17, 2012, the Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of Nursing Services, and/or Weekend Supervisor, initiated education with all Licensed Nurses and Certified Medication Technicians related to Care Plan Implementation related to	

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medications, including "pre-printed" and on Care Plan Review and Revision. Education complete on 7/23/12. The SDC will include information on Care Plan Implementation related to medications in the orientation of new personnel.

On July 20, 2012, the Staff Development Coordinator and/or Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers and/or Weekend Supervisor initiated education with all Licensed Nurses related to Kindred clinical abbreviations, to include symbols and acronyms. Education was complete on 7/23/12. The SDC will include information related to Kindred clinical abbreviations, to include symbols and acronyms in the orientation of new personnel.

4) The Unit Managers and/or Registered Nurse Weekend Supervisor will review all new physician orders and care plan updates for transcription accuracy and

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implementation of medication interventions Monday – Friday until deemed unnecessary as determined by the Performance Improvement Committee. Audit findings will be documented on a Medical Doctor Transcription audit. Any identified concerns will be corrected immediately by the Unit Manager and/or Registered Nurse Weekend Supervisor with appropriate follow-up with the licensed nurse.

All audit findings will be reviewed at the monthly Performance Improvement Committee x 3 months and then quarterly thereafter until deemed unnecessary.

The Administrator and/or DNS are responsible to ensure compliance with this standard.