

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2011
NAME OF PROVIDER OR SUPPLIER KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(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	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Klondike Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F202</p> <p>1. Resident #1 was discharged on 10/30/11 with a clarification physician documented discharge/transfer written on 11/9/11 by the Medical Director. Resident #9 was readmitted to the center on 7/25/11.</p> <p>2. Residents discharged or transferred from the facility since 11/10/11 were reviewed by the Director of Nursing and Social Services on 12/2/11. No other residents were identified.</p>	
F 202 SS=D	<p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and the facility discharge log, it was determined the facility failed to provide a discharge notice to two (2) of nine (9) residents, Resident #1 and Resident #9. Resident #1 was discharged on 10/30/11 and was not able to return to the facility and Resident #9 was notified of bed-hold notice from the facility on 07/05/11. However, the facility was unable to provide evidence of physician documented discharge and/or transfer for Resident #1 and Resident #9.</p> <p>The findings include:</p>	F 202		

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DIVISION OF HEALTH CARE FACILITIES (X5) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Diane Harrett

Administrator

12/6/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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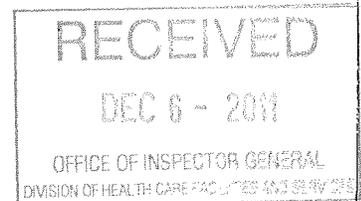
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F 202	Continued From page 1 The closed clinical record review, on 11/07/11 for Resident #1 revealed he was sent to the local hospital on 10/30/11. Review of Resident #1's Patient Progress Notes from the hospital, dated 10/30/11 at 11:25 PM, revealed this facility notified the hospital this resident would not be readmitted related to his/her escalated behaviors. Reviewed the facility discharge log, on 11/09/11 at 5:45 PM, revealed Resident #1 was discharged on 10/30/11. Review of clinical record, revealed Resident #1 was sent to the hospital on 10/30/11 and was not readmitted to the facility. The facility was unable to provide evidence of a physician documented discharge or transfer. Record review of Bed-Hold notice, dated 07/05/11 revealed Resident #9 was provided a bed-hold notice from the facility. The facility was unable to provide evidence of physician documented discharge and/or transfer for Resident #9. However, the clinical record revealed Resident #9 was re-admitted to the facility on 07/25/11. Interview with the Administrator, on 11/10/11 at 11:30 AM revealed she was not aware the physician had not completed the discharge and transfer documentation for these residents.	F 202	3. The Administrator was re-educated by the Director of Clinical Operations regarding the need for physician documentation regarding discharge and transfer on 12/2/11. The Director of Nursing, Social Services and Medical Records were re-educated 12/2/2011 by the Administrator regarding physician documentation of transfers and discharges. Licensed nursing staff will be re-educated by the Director of Nursing or Assistant Director of Nursing on physician documentation regarding discharge and transfer by 12/9/2011. The Medical Director and Nurse Practitioner were re-educated on 12/2/2011 regarding required documentation for discharge and/or transfers by the Administrator 4. The Director of Nursing will conduct an audit weekly of discharged/transferred residents for 4 weeks and then monthly times 2 months to ensure physician documentation. The Director of Nursing will submit findings to the Performance Improvement Committee (Administrator, Medical Director, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations. 5. Date of compliance 12/10/11		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a	F 203			

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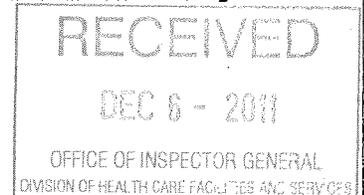
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F 203	<p>Continued From page 2</p> <p>resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the</p>	F 203	<p>F203</p> <ol style="list-style-type: none"> 1. Resident #1 was discharged on 10/30/2011 from the facility. On 11/11/11 the written discharge notice was sent to Resident #1 and all required agencies by the Administrator. 2. Resident's who were discharged/transferred in the past 7 days were reviewed for notice of discharge/transfer by the Administrator and Social Services Director on 12/2/2011. No residents were identified. 3. The Administrator and Director of Nursing were educated on transfer/discharge notification on 12/2/2011 by the Director of Clinical Operations. The Administrator re-educated the Social Services Director on transfer/discharge notification on 12/2/11. 4. The Social Services Director will review resident discharges weekly for 4 weeks then monthly times 3 months to ensure notification is given regarding transfer/discharge. The Social Services Director will submit the findings to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, 	



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F 203	<p>Continued From page 3</p> <p>protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and the facility discharge log, it was determined the facility failed to provide a discharge notice to one (1) of nine (9) residents, Resident #1. The facility staff notified the receiving facility that Resident #1 was discharged on 10/30/11 and was not able to return to the facility. However, the facility was unable to provide evidence of a discharge notice issued to Resident #1, as of 11/10/11.</p> <p>The findings include:</p> <p>The closed clinical record review, on 11/07/11 for Resident #1, revealed he/she was admitted on 06/15/11 with the diagnosis of CVA (Stroke), Left Sided Hemiparesis (paralysis), High Blood Pressure, Immobility Syndrome, Aggressive Behaviors and Depressive Disorder. The facility assessed him/her on admission, 06/22/11 and on the quarterly, 09/02/11 with a cognition score of fifteen (15). The clinical record revealed Resident #1 was his/her own power of attorney (POA). Resident #1 was discharged on 10/30/11.</p>	F 203	<p>Social Service Director, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations.</p> <p>5. Date of compliance 12/10/2011</p>	



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F 203	<p>Continued From page 4</p> <p>Reviewed Resident #1's Patient Progress Notes from the local hospital, dated 10/30/11 at 11:25 PM, revealed this facility notified the local hospital this resident would not be accepted back. The patient progress notes documented the local hospital notified the resident's mother he/she would not take him/her back. The patient progress notes at the local hospital, dated 10/31/11 revealed the administrator advised the resident was not welcomed back.</p> <p>Reviewed of the facility discharge log listed Resident #1 as discharged on 10/30/11.</p> <p>Clinical record review revealed Resident #1 did not have evidence of a discharge notice issued since the resident was sent to the local hospital on 10/30/11. The facility was unable to provide evidence of a discharge notice issued to Resident #1, as of 11/10/11.</p> <p>Interview with the Administrator, on 11/10/11 at 11:30 AM revealed she did not issue a discharge notification to the resident or his/her family. She reported she was not aware she needed to issue a discharge notice.</p>	F 203		

