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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	(X3) DATE SURVEY COMPLETED
	185346	A. BUILDING _____ B. WING _____	04/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 An annual recertification survey and an abbreviated survey (KY #18193) was conducted on 04/18/12 through 04/20/12, and a Life Safety Code survey was conducted on 04/19/12 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "H." An extended survey was conducted on 04/20/12. Substandard Quality of Care was identified on 04/20/12 at 42 CFR 483.25 Quality of Care (F323). KY #18193 was substantiated with deficiencies cited.	F 000	Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers it response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided met professional standards of quality related to administration of medications per the physician's order for one resident (#18), in the selected sample of eighteen residents. Findings include: A review of the facility's policy/procedure, "Physician Visits and Medical Orders," effective December 2010, revealed members of the interdisciplinary team were to provide care, services, and treatment according to the most recent medical orders and according to laws,	F 281	1. Resident #18 that was affected by the alleged deficient practice was discharged from the facility on 4/2/12. 2. All other resident's Medication Administration Records Sheet and medications were checked by the Administrative Nurses on 04/23/2012 to ensure no other residents were affected by the alleged deficient practice. Medication Administration Records were audited to ensure pain medications were administered to include control substance. No other deficient practice was identified	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill S | TITLE: Administrator | (X6) DATE: 5/14/12

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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F 281	Continued From page 1 regulations, and standards of practice. A record review revealed the facility admitted Resident #18 on 03/29/12 with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD), Rheumatoid Arthritis (RA), Lupus, Depression, Hypertension (HTN), and Left Total Knee Revision. A review of the Nursing Admission Information, dated 03/29/12, revealed the facility identified the resident as alert and oriented. A review of the physician's admission orders, dated 03/29/12, revealed "Prednisone 5 milligrams (mg) twice daily for COPD, Neurontin 300 mg twice daily for Rheumatoid Arthritis and Lupus, Ferrous Sulfate 325 mg twice daily for 30 days, Plavix 75 mg daily due to Left Total Knee Revision, Atenolol 50 mg daily for HTN, Furosemide 40 mg daily, and Zoloft 50 mg daily for Depression. A review of the Medication Administration Record (MAR), dated 03/12, revealed the following medications were initialed and circled (as not administered) or not initialed as given, on 03/29/12: Prednisone 5 (mg), Neurontin 300 mg, and Ferrous Sulfate 325 mg. The following medications were initialed and circled (as not administered) or not initialed as given, on 03/30/12: Atenolol 50 mg, Furosemide 40 mg, Ferrous Sulfate 325 mg, Plavix 75 mg, Neurontin 300 mg, and Zoloft 50 mg. A review of the medication list from the facility's emergency kit, undated, revealed all the above listed medications were available in the facility.	F 281	3. Director of Nursing and the Staff Development Director will in-service on 05/11/2012 licensed nursing staff and Certified Medication Technicians on all new residents or new medication orders. The in-service will include policy and procedure for medication administration, ordering and reordering medications including narcotics, pain management, use of emergency drug kit and notifying Director of Nursing when medications are unavailable, obtaining all medications available through the Emergency Drug Kit for new residents or new medication orders, a list of all Emergency Drug Kit medications will be posted at each nursing station and each Medication Administration Record book, 5 rights of medication administration, 24 hour review of all new orders to be conducted by evening nurses (7p-7a shift), and procedure for immediate notification of backup pharmacy if medications are not available in the Emergency Drug Kit, and ordering medications to ensure timely administration. Pharmacy Consultant to provide in-service on process of securing medications, ordering medications and administration. Licensed Nursing Administrative team will be assigned a specific hall to review daily x 72 hours, Medication Administration Records for missed medication dose for new admissions or residents with new medication orders.	

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F 281	Continued From page 2 An Interview with Licensed Practical Nurse (LPN) #4, on 04/20/12 at 1:10 PM, revealed she passed medications the night of 03/29/12. She revealed there was no Ferrous Sulfate in the emergency kit. She further revealed she should have given the other medication from the emergency kit. An interview with Registered Nurse (RN) #1, on 04/20/12 at 9:30 AM, revealed she passed medications on the morning of 03/30/12. She revealed some of the resident's medications were not received from pharmacy, so they were "initialed and circled" on the MAR to indicate the resident did not receive them. She revealed she should have gotten the resident's medications from the emergency kit. An interview with the Pharmacy Director, on 04/20/12 at 3:00 PM, revealed the emergency kit was replaced three times a week. An interview with the Director of Nursing (DON), on 04/20/12 at 4:15 PM, revealed the staff were expected to use the emergency kit if a resident's medications were not available.	F 281	This will ensure medications are given as ordered. Director of Nursing will audit monthly 10% of new medication orders to ensure resident medications are ordered, available, administered and effective. The Director of Nursing will review monthly the Emergency Drug Kit forms to ensure Emergency Drug Kit is being utilized properly for all medications that are not timely delivered and/or not available for the residents as prescribed. 4. The Nursing Administrative team will report findings to Director of Nursing in the daily clinical meeting to ensure proper follow up. Any deficient practice identified will be reported to the administrator immediately by the Director of Nursing. Further investigation will be completed by the Director of Nursing and Administrator with appropriate action as necessary. Director of Nursing will report findings to the monthly Quality Assurance Committee for 3 months for monitoring and follow up by the quality assurance committee and the Medical Director. 5. Corrective Action Date: 06/01/12	6/1/12
F 282 SS=H	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, Interview and record review, it was determined the facility failed to	F282		

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F 282	Continued From page 3 provide care according to the written plan of care for two residents (#1 and #4), in the selected sample of 18 residents. The facility failed to provide adequate supervision to Resident #4 as directed on the Comprehensive Care Plan to prevent repeated falls. On 01/27/12, Resident #4 was admitted to the facility with a history of falls at home. The Plans of Care for January, March, and April identified falls on 01/31/12, 03/18/12, 04/16/12, and 04/17/12, with the initiated interventions related to alarms and observations of the resident. On 03/30/12, Resident #4 sustained a hip fracture which required surgical intervention as a result of a fall where the resident was left unattended in his/her room. On 04/06/12, Resident #4 was readmitted to the facility and determined at high risk for falls. Resident #4 suffered additional unobserved falls on 04/16/12 and on 04/17/12 where staff continued to not follow the care leaving the resident unattended while up in the wheelchair in the residents room. The facility failed to implement care plan interventions for Resident #1 to prevent accidents and/or injury for the resident. The facility assessed the resident at high risk for falls and developed care plan interventions to address the risk for falls; however, the facility failed to follow the planned interventions and provide the assistive devices deemed appropriate to prevent accidents and/or injuries to Resident #1. Findings include: An interview with the Director of Nursing (DON), on 04/20/12 at 4:00 PM, revealed the facility did not have a policy and procedure that specifically addressed the implementation of the care plan.	F 282	1. Resident #4 that was affected by the alleged deficient practice was placed on 1:1 supervision on 04/20/12 by the Administrator and Director of Nursing. Resident #1 was reassessed by the unit Assistant Director of Nursing for need for alarms and alarms were discontinued on 04/21/12. Pressure bed alarm and the personal alarm were discontinued 04/24/12. 2. Residents who have experienced a fall within the last 30 days had a complete chart review by the licensed nursing administrative team on 4/22/12 to ensure appropriate interventions were in place. On 04/22/12 all residents were reassessed and new fall risk assessments were documented and care plan audits for residents at risk for falls was completed by licenses nursing administrative team. 3. Director of Nursing and Staff Development Coordinator in-serviced licensed nursing staff April 27th, 2012 on root cause analysis, appropriate fall interventions, change of condition, physician/responsible party notification, falling star program, recognizing when to discontinue an ineffective current fall intervention that is not working and/or agitating the resident, care plan updating, incident & accident reporting, obtaining witness statements, survey and/or recreate	

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F 282	Continued From page 4 1. A record review revealed the facility admitted Resident #4 on 01/27/12 with diagnoses to include Fatigue, Generalized Weakness, Chronic Back Pain, Hypertension, and Left Ventricular Hypertrophy. A review of the Discharge/Transfer form, dated 01/27/12, revealed activity limitations needed with falls precautions. A review of the Interim Plan of Care, dated 01/27/12, revealed Resident #4 was at risk for falls. A review of the Admission Interim Plan of Care, dated 01/27/12, revealed the facility assessed Resident #4 at risk for falls with interventions to include verbal reminders not to ambulate alone, his/her bed to be in the lowest position, assistance with transfers and ambulation as needed, and observe for any unsafe actions and intervene as needed. A review of the admission Minimum Data Set (MDS) assessment, dated 02/03/12, revealed the facility assessed Resident #4 at risk for falls with a history of falls prior to admission to the facility, and the resident required extensive assistance for walking within his/her room and did not walk in the corridors during the time of the MDS evaluation. A review of the Comprehensive Care Plan for falls, dated 02/03/12, revealed interventions to provide a personal body alarm to be on at all times and a pressure bed alarm on while Resident #4 was in the bed. Further review of the Comprehensive Care Plan revealed an update, on 03/16/12, to discontinue the intervention of a personal alarm on at all times. A review of the Care Plan for "head injury from	F 282	the accident scene immediately, updating Certified Nurse Aide/ Treatment Administration Records with new interventions, documenting on incident/accidents for 72 hours, place on 24 hour report & neurological checks both for 72 hours. In-service was also conducted with Certified Nursing Aides on May 16th 2012 regarding resident fall interventions, resident alarms, Certified Nurse Aide care records and falling star program. 4. Fall management performance improvement will be completed by Director of Nursing and/or Assistant Directors of Nursing with each fall to ensure all steps taken. Acuity by hall sheets are updated daily by interdisciplinary team. Acuity sheets show all interventions including falls developed and updated daily in morning stand up meeting to ensure Fall interventions are followed per care plan. Interdisciplinary team will audit 10% of alarms daily times 4 weeks and 7p-7a Charge Nurse will audit 10% of alarms nightly times 4 weeks and findings will be reported to clinical white board meeting and quality assurance committee for review and follow up. All incident/accident reports will be brought to clinical white board meeting daily times 72 hours to review medical chart by interdisciplinary team for revisions and follow up to the care plans. Investigation	

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F 282	Continued From page 5 fall", dated 03/18/12, revealed the facility developed interventions for staff to encourage Resident #4 to be in the lobby for observation and to not be left unattended while up in the wheelchair. A review of the Plan of Care for "head injury from fall", dated 03/18/12, was updated on 03/23/12 and documented their knowledge that the resident refused to leave alarms on, takes them off and hides them; however, maintained these interventions to prevent falls. A review of Physician's Orders, dated 03/29/12, revealed Resident #4 was to have personal (clipped to clothing) and pressure bed alarms on at all times. A review of the "Fall/Change in Functional Status," dated 03/30/12, revealed a CNA found Resident #4 sitting on the floor in his/her room and was unattended. The facility assessed the resident for injuries and found a skin tear on the left elbow and Resident #4 was complaining of hip pain. An interview with CNA #8, on 04/19/12 at 3:00 PM, revealed the fall on 03/30/12 occurred during the supper meal while Resident #4 was alone in his/her room. CNA #8 stated she found the Resident #4 sitting on the floor. Interview with RN #5, on 04/20/12 at 9:10 AM, revealed she was called from the dining room to find that Resident #4 had fallen. RN #5 found the resident sitting in the wheelchair and complaining of hip pain. RN #5 reported the alarms were sounding when Resident #4 fell and staff reported they found him/her sitting in the floor of his/her room alone. The facility did not identify that Resident #4's care plan was not being followed as the resident was left unattended in his/her	F 282	report will be brought to clinical white board meeting and root cause analysis will be identified and added to the incident/accident by licensed nursing administrative team. After review of incident/accident reports at clinical white board meeting with interdisciplinary team any educational referrals will be made to Staff Development Coordinator for 1:1 education with nurses identified as needing educational needs in "investigation and root cause analysis". Interdisciplinary team will report findings to DON and DON will report findings to Quality Assurance team monthly for 3 months for monitoring and follow up by Quality Assurance Committee and the Medical Director. 5. Corrective Action Date: 06/01/12	6/1/12

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F 282	Continued From page 6 room and was not in the lobby. A review of the physician's order, dated 03/30/12, and Nurse's Notes, dated 03/31/12 at 7:00 AM, revealed that Resident #4 had sustained a left hip fracture. Resident #4 was transferred to the Emergency Room for surgical repair on 03/31/12. A review of the "Admission Information," dated 04/06/12 at 6:00 PM, revealed Resident #4 was admitted to the facility after surgical repair of the left hip fracture sustained in the facility on 03/30/12. The facility assessed the resident to be at high risk for falls. A review of the Interim Plan of Care, dated 04/06/12, revealed the interventions for falls included the bed be in the lowest position, verbal reminders not to ambulate alone, assistance with transfers and ambulation as needed, observe for unsteady gait, dizziness, and intervene as needed, and pressure bed alarms and chair alarms. There were no interventions to address Resident #4's demonstrated ability to remove the alarms or the need for increased supervision due to the resident's history of falls at the facility. A review of the Care Plan for "resident fell", dated 04/16/12, revealed an intervention for the resident to be in the lobby while up in the wheelchair and the resident was non-compliant with the alarms and will not stay off hip. A review of the "Fall/Change in Functional	F 282		

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F 282	Continued From page 7 Status," dated 04/16/12, revealed Resident #4 was found sitting on the floor in his/her room. The assessment revealed no apparent injury was sustained. An interview with RN #5, on 04/20/12 at 9:10 AM, revealed the fall was unobserved so it must be treated as a fall. An interview with CMT #3, on 04/20/12 at 10:30 AM, revealed Resident #4 was found sitting on the floor in his/her room alone. There was no evidence that the facility identified that staff was not following the care plan related to the resident was to be in the lobby while up in the wheelchair and not be left unattended while in the room. A review of the Care Plan, dated 04/17/12, revealed the facility initiated no interventions related to the prevention of further falls. A review of the "Fall/Change in Functional Status," dated 04/17/12, revealed two (2) unobserved falls within a one and a half (1.5) hour time period. The record revealed Resident #4 was found sitting in the floor of his/her room unattended. The resident was assisted back into the wheelchair, the alarms were turned off, and the RN #5 left Resident #4 alone in the room. The facility did not follow the care plan intervention of using the pressure chair alarm in that the alarm was turned off after the resident was assisted back into the wheelchair. In addition, the facility did not follow the care plan intervention of resident to be in the lobby when in the wheelchair. An interview with RN #5, on 04/20/12 at 9:10 AM, revealed Resident #4 was alone in the room when the chair and bed alarms sounded. The resident was found sitting in the floor, was returned to the wheelchair, and RN #5 left the room. RN #5 stated, upon her return, she found Resident #4 on the opposite side of the	F 282		

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F 282	Continued From page 8 bed, on hands and knees, trying to pull the bed control cord from the bed frame. The resident was unattended and the fall was not observed. An interview with CNA #7, on 04/20/12 at 12:40 PM, revealed, CNA #7 found Resident #4 in his/her room alone after the chair alarm sounded on 04/17/12. CNA #7 revealed Resident #4 was taken for activities but would leave the activity and self-propel back to his/her room unassisted. Supervision after the falls included taking the resident out of the room while in the wheelchair and parking the resident's wheelchair at the nurse's station, but he/she always wanted to return to the room to be alone. An observation, on 04/18/12 at 11:40 AM, revealed Resident #4 was in bed with his/her eyes closed and was unattended. On 04/19/12 at 8:55 AM, the resident was returned to the room from physical therapy and was in his/her wheelchair. The facility staff provided Resident #4 with activities and left the resident alone in the room. An observation, on 04/19/12 at 2:00 PM and at 2:30 PM, found Resident #4 laying in the bed unattended with his/her eyes closed. The personal body alarm was attached to the resident's clothing and the bed alarm activation light was blinking. The resident was unattended. An observation, on 04/20/12 at 1:30 PM, revealed Resident #4 was observed in the bed with a personal body alarm in place. The pressure bed alarm activation light was not blinking and the	F 282		

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F 282	Continued From page 9 staff was notified. The resident was unattended. An observation, on 04/20/12 at 4:25 PM, revealed Resident #4 was sitting in his/her wheelchair in the doorway of his/her room in a forward drooped position with his/her eyes closed. The resident did not respond to a verbal greeting. An interview with CMT #3 revealed Resident #4 received Lortab 5/325 mg for pain at 11:00 AM, and received Ativan for anxiety at 12:00 PM. At 4:33 PM, Resident #4 remained in the wheelchair in his/her the doorway of his/her room. His/her posture was more erect at that time. The resident responded to a verbal greeting by lifting his/her head and opening his/her glassy eyes. His/her mouth fell open from a relaxed jaw, but no verbal response was given. The Director of Nursing (DON), on 04/20/12 at 3:10 PM, revealed the facility had staffing to ensure adequate supervision was provided for Resident #4 to keep him/her safe. The DON stated if the nursing staff was busy, she could notify other facility departments, such as activities or the chaplain, to attend to the resident. The DON stated Resident #4 cannot be forced to stay at the nurse's station and the staff cannot keep the resident on one-to-one supervision, as the staff had to take care of other residents. The DON reported the facility ensured the safety of Resident #4 the same way as they do for all residents by moving around the facility and ensuring whereabouts of the residents. Another method of ensuring safety, reported by the DON, was "team tackling" and described this method as part of internal audits and the review of different topics each day. However, the DON was unable to provide evidence that the facility had identified	F 282		

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	185346	A. BUILDING _____ B. WING _____	04/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 10 their failure to ensure interventions developed to prevent recurrence of falls was implemented. These failures continued even after the resident sustained a fall resulting in hip fracture which required surgical repair. 2. A record review revealed the facility admitted Resident #1 on 10/17/07 with diagnoses to include Cerebral Vascular Accident (CVA) with left-sided hemiparesis and Psychoses with hallucinations. A review of the quarterly MDS assessment, dated 02/02/12, revealed the facility assessed Resident #1 as cognitively intact and requiring minimal assistance of one staff for ambulation. A review of the Falls assessment, dated 02/02/12, revealed the facility assessed Resident #1 at high risk for falls. A review of the Comprehensive Care Plan for falls, dated 02/06/12, revealed the facility developed interventions for Resident #1 to have a personal alarm in place at all times while in the wheelchair and a pressure alarm in place when in the bed. Observations, on 04/18/12 at 10:30 AM, 3:50 PM, 4:35 PM and 4:55 PM, and on 04/19/12 at 9:30 AM, 10:55 AM, 11:40 AM and 1:50 PM, revealed Resident #1 was up in his/her wheelchair with no alarm on the chair. Observations of the resident's bed revealed there was no pressure alarm in place. An observation and an interview with LPN #1, on 04/19/12 at 10:10 AM, revealed Resident #1 was up in the wheelchair with no alarm on the chair,	F 282		

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F 282	Continued From page 11 and when the nurse checked the resident's bed, there was no pressure alarm under the sheet in the bed. She stated Resident #1 was supposed to have a clip alarm on his/her wheelchair and a pressure alarm on the bed. She was unable to provide an explanation as to why the alarms were not in place. Interviews with CNA #4 and CNA #5, on 04/20/12 at 9:15 AM and 10:25 AM, respectively, revealed Resident #1 should have had a chair alarm and bed alarm; however, they were unable to provide an explanation as to why the alarms were not in place. An interview with the DON, on 04/20/12 at 4:00 PM, revealed Resident #1's alarms should have been on the wheelchair and the bed. Interview with the Director of Nursing (DON), on 04/20/12 at 3:10 PM, revealed the process for evaluation of effective interventions was to determine why an intervention was not in place, to educate and coach the staff. Further evaluation of interventions for Resident #4 were monitored weekly through clinical meetings, Interdisciplinary Team meetings, and "at risk" meetings. The team talked about behaviors on a daily basis and with any change in condition.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	1. Resident #18 that was affected by the alleged deficient practice discharged from the facility on 4/2/12. 2. All other resident's narcotic count sheets were reviewed by licensed Nursing Administrative team on 04/23/2012 to ensure an adequate supply of physician ordered narcotics were available and that other residents	

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F 309	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedures, it was determined the facility failed to ensure each resident received the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being, related to the administration of pain medication for one resident (#18), in the selected sample of eighteen residents. Findings include: A review of the facility's policy/procedure, "Pain Management," dated December 2010, revealed unrelieved pain was a stressor that could cause both physical and psychological strain. Without proper management it would actually lead to pathological changes such as complications with immobility and malnutrition. Each resident identified with pain would have an ongoing assessment, a monitoring system, and a specific plan of care to address these issues. A record review revealed the facility admitted Resident #18 on 03/29/12 with diagnoses to include Left Total Knee Revision, Migraines, Rheumatoid Arthritis, Osteoporosis, and Fibromyalgia. A review of the Nursing Admission Information, dated 03/29/12 at 4:00 PM, revealed the facility assessed the resident as alert and oriented. A review of the Pain Evaluation revealed daily severe incisional pain and moderate joint pain. The Instructions on the Pain Evaluation	F 309	were not affected by the alleged deficient practice. Medication Administration Records were audited to ensure pain medications were administered to include control substance. No other deficient practice was identified. 3. Director of Nursing and Staff Development will in-service on 05/11/2012 all licensed nursing staff and Certified Medication Technicians on policy and procedure for medication administration, ordering and reordering medications including narcotics, pain management, use of emergency drug kit and notifying Director of Nursing when medications are unavailable. Pharmacy Consultant to provide in-service on process of securing medications, ordering medications and administration. Licensed Nursing Administrative team will be assigned a specific hall to review weekly for 3 months narcotics and medications to ensure they have been ordered in a timely manner. Director of Nursing will audit monthly 10% of resident's narcotics and medications to ensure they are ordered, available, administered and effective. Nursing Administrative team will report findings to Director of Nursing weekly to ensure proper follow up by the Director of Nursing. Director of Nursing will report weekly audits to the administrator for further follow up and education as needed.	

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F 309	Continued From page 13 revealed to consult the physician if pain management was ineffective. Interventions should be implemented immediately and documented on the resident's care plan. Documentation from the Nursing Admission Skin Assessment, dated 03/29/12, revealed the resident rated his/her pain as a "7" with movement, and according to the Pain Evaluation Scale, a "7" indicated very severe pain. A review of the physician's orders, dated 03/29/12, revealed "Percocet (narcotic pain medication) 5/325 milligrams (mg) every four hours as needed for severe pain." A review of the Controlled Medication Record, dated 03/29/12, revealed Resident #18 received two (2) Percocet 5/325 mg at 6:50 PM, which was almost three hours after admission to the facility. An interview with Licensed Practical Nurse (LPN) #3, on 04/20/12 at 8:45 AM, revealed she was the nurse who completed the resident's admission paperwork, on 03/29/12. She recalled the resident was in pain because of the long drive from the hospital to the facility. She revealed the resident's medications were ordered "stat" (immediately), but it could take up to four hours to receive "stat" medications from the back-up pharmacy. She revealed the nurse working the unit should have called the physician for another pain medication order, until the resident's medications arrived at the facility. An interview with Registered Nurse (RN) #2, on 04/20/12 at 10:25 AM, revealed she was the resident's nurse, on 03/29/12. She stated that the	F 309	4. The Administrator will report audit results to the monthly quality assurance committee team for 3 months for monitoring and follow up by the quality assurance committee and the Medical director. 5. Corrective Action Date: 06/01/12	6/1/12

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F 309	Continued From page 14 resident had knee pain upon admission, but she was unsure of the severity. She revealed it could take between one and three hours to receive a new resident's medications. She could have notified the physician for other pain medication, but she stated that the resident stated he/she could "hold off" until the medication was received from the pharmacy. An interview with the Director of Nursing (DON), on 04/20/12 at 4:15 PM, revealed she expected the staff to offer a resident non-pharmacological pain interventions (such as massage, dim lighting, sound level control), until the resident's pain medications arrived from the pharmacy. She revealed the physician should be notified for other medication options, if these techniques were ineffective. Additionally, the facility failed to ensure the resident's Percocet was reordered timely. A review of the Pharmacy Services Agreement, effective 01/01/10, revealed the pharmacy provided, maintained, and replenished, in a prompt and timely manner, and within twenty-four hours of the request. A review of the Controlled Medication Record, dated 03/29/12, revealed the resident's last two Percocet were signed out by RN #2, at 5:10 PM on 04/02/12. A review of the Refill Re-Order Sheet, dated 04/02/12, revealed a re-order request for the resident's Percocet with a note which said "need today." The sheet was received by the pharmacy at 12:46 PM, on 04/02/12.	F 309		

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F 309	Continued From page 16 A review of the Nurse's Notes, dated 04/02/12 at 7:30 PM, revealed LPN #4 placed a call to the pharmacy to verify the resident's Percocet were going to be delivered to the facility. The pharmacy informed the nurse a "new script" was needed for the narcotic prior to delivery. At 8:15 PM, Resident #18 was offered Tylenol (non-narcotic pain medication) as the Percocet had not been received. The resident refused and left the facility against medical advice. A review of the Shipping Manifest, dated 04/03/12, revealed the resident's Percocet was delivered to the facility at 12:15 AM (four hours after a dose could have been given). An interview with RN #2, on 04/20/12 at 10:26 AM, revealed she recalled re-ordering the resident's Percocet on 04/02/12; however, she was unsure of the time she called the pharmacy. An interview with the Pharmacy Director, on 04/20/12 at 3:00 PM, revealed she did not have a record of a call requesting the Percocet. An interview with LPN #4, on 04/20/12 at 1:10 PM, revealed the resident's Percocet was completely out at shift change, on 04/02/12 at 7:00 PM. She revealed RN #2 reported to her that she called the pharmacy to reorder the medication and it would arrive from the back-up pharmacy. LPN #4 revealed she made a phone call to the pharmacy after a report to check the status of the medication. She revealed the pharmacy informed her they needed a "new script" before the medication could be delivered. She notified the physician and had him fax a "new script" to the pharmacy. She revealed the	F 309		

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F 309	Continued From page 16 medication arrived after the resident left the facility against medical advice. She revealed the medication should have been ordered earlier to ensure the resident did not miss a dose. An interview with the DON, on 04/20/12 at 4:15 PM, revealed nurses were suppose to monitor and ensure the labels on medications were pulled for re-order timely.	F 309		
F 323 SS=H	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide assistive devices or supervision to prevent accidents and/or injury for two residents (#1 and #4), in the selected sample of eighteen residents. The facility failed to provide adequate supervision for Resident #4 to prevent falls and/or other injuries and failed to ensure interventions implemented were effective in preventing falls for the residents. The facility assessed Resident #4 as a high risk for falls due to his/her history of falls. The resident sustained six falls between 01/31/12 and 04/17/12. On 01/31/12, Resident	F 323	1. Resident #4 that was affected by the alleged deficient practice was placed on 1:1 supervision on 04/20/12 by the Administrator and Director of Nursing. Resident #1 was reassessed by the ADON of the unit for need for alarms and alarms were discontinued on 04/21/12. Pressure bed alarm and the personal alarm were discontinued 04/24/12. 2. Residents who have experienced a fall within the last 30 days had a complete chart review by the licensed nursing administrative team on 4/22/12 to ensure appropriate interventions were in place. On 04/22/12 all residents were reassessed and new fall risk assessments were documented and care plan audits for residents at risk for falls was completed by licenses nursing administrative team. 3. Director of Nursing and Staff Development Coordinator in service licensed nursing staff April 27th 2012 on root cause analysis, appropriate fall interventions, recognizing when to discontinue an ineffective current fall intervention, that is not working and/or	

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F 323	Continued From page 17 #4 sustained a skin tear. On 03/18/12, the resident sustained a laceration to the back of the head. On 03/30/12, Resident #4 suffered a hip fracture as a result of the fall. The facility's incident investigations failed to identify causal factors of the falls to prevent recurrence. The facility failed to identify that staff was not implementing the care plan related to supervision and failed to identify that the resident was agitated by the alarms. The facility continued to utilize interventions despite having knowledge that the resident was known to remove and hide the alarms that were placed by the facility to monitor the resident's movement and would propel him/herself back to the resident's room without staff supervision after staff placed the resident in the lobby. The facility continued these interventions failing to determine their ineffectiveness and failing to implement new interventions to prevent fall recurrence. This failure led to the residents continued fall occurrences on 04/16/12, and twice on 04/17/12 placing the resident at further risk for falls with potential for injuries. The facility failed to provide assistive devices to prevent accidents and/or injury for Resident #1. The facility assessed the resident at high risk for falls and developed care plan interventions to address the risk for falls. The facility failed to follow the planned interventions and provide the assistive devices deemed appropriate to prevent accidents and/or injuries to Resident #1. Findings include: A review of the facility's policy and procedures for	F 323	agitating the resident, care plan updating, incident & accident reporting, survey and or recreate the accident scene immediately, updating Certified Nurse Aide/ Treatment Administration Records with new interventions, documenting on incident/accidents times 72 hours, place on 24 hour report & conduct neurological checks both for 72 hours. In-service was also conducted with Certified Nursing Aides on May 16th 2012 regarding resident fall interventions, resident alarms, Certified Nurse Aide care records and falling star program. 4. Fall management performance improvement will be completed by Director of Nursing with each fall to ensure all steps taken to include appropriate interventions and follow up. Acuity by hall sheets are updated daily by interdisciplinary team. Acuity sheets show all interventions including falls developed and updated daily in morning stand up meeting to ensure Fall interventions are followed per care plan. Interdisciplinary team will audit 10% of alarms daily times 4 weeks and 7p-7a Charge Nurse will audit 10% of alarms nightly times 4 weeks and findings will be reported to clinical white board meeting and quality assurance committee for review and follow up.	

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F 323	Continued From page 18 "Falls," dated 12/10, revealed it was the intent of this facility to provide residents with assistance and supervision in an effort to avoid falls and minimize injury and complications that may result from a resident falling. A review of the facility's Incident Reporting policy and procedure, dated 12/10, revealed the facility shall ensure that each resident shall receive adequate supervision and assistive devices that shall reduce accidents. 1. A record review revealed the facility admitted Resident #4 on 01/27/12 with diagnoses to include Fatigue, Generalized Weakness, Chronic Back Pain, Hypertension, and Left Ventricular Hypertrophy. A review of the Discharge/Transfer form, dated 01/27/12, revealed Activity Limitations included falls precautions. A review of the Interim Plan of Care, dated 01/27/12, revealed the facility identified Resident #4 was at risk for falls. Interventions included verbal reminders not to ambulate alone, his/her bed to be in the lowest position, assistance with transfers and ambulation as needed, and observe for any unsafe actions and intervene as needed. A review of the "Incident Accident Tracking Log," dated 01/31/12 at 10:00 AM, revealed Resident #4 turned off the pressure alarm, got out of bed, stumbled and fell, which resulted in a skin tear to the right arm. A review of the Plan of Care, dated 01/31/12, revealed the facility initiated an intervention conducting neurological checks and clean the steri strips applied to the skin tear on right arm. A Plan of Care entry on 03/07/12 identified the skin tear as healed.	F 323	All incident/accident reports will be brought to clinical white board meeting daily times 72 hours to review medical chart by the interdisciplinary team for revisions and follow up to the care plans. Investigation report will be brought to clinical white board meeting and root cause analysis will be identified and added to the incident/accident. After review of incident/accident reports at clinical white board meeting with interdisciplinary team any educational referrals will be made to Staff Development Coordinator for 1:1 education with nurses identified as needing educational needs in "investigation and root cause analysis". Interdisciplinary team will report findings to Director of Nursing and the Director of Nursing will report findings to Quality Assurance team monthly for 3 months for monitoring and follow up by Quality Assurance Committee and the Medical Director. 5. Corrective Action Date: 06/01/12	6/1/12

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F 323	Continued From page 19 A review of the Admission Minimum Data Set (MDS) assessment, dated 02/03/12, revealed the facility assessed Resident #4 as at risk for falls with a history of falls prior to admission to the facility. The resident required extensive assistance for walking in his/her room, but did not walk in the corridors at the time of the MDS evaluation. A review of the Comprehensive Care Plan for falls, dated 02/03/12, revealed interventions included a personal alarm on at all times and a pressure bed alarm on while in the bed. Further review of the Comprehensive Care Plan for falls, dated 02/03/12, and updated on 03/16/12, revealed the intervention for the personal alarm was discontinued. A review of the "Fall/Change in Functional Status," dated 03/18/12 at 6:30 AM, revealed Resident #4 had an unobserved fall which resulted in a hematome, 7 centimeter (cm) by 4 cm laceration injury to the back of his/her head, and a bruise on the left thumb. The resident stated he/she fell on the floor. A review of the "Incident Accident Tracking Log," dated 03/18/12 at 6:30 AM, revealed Resident #4 attempted to go to the bathroom unassisted and fell, hitting his/her head. An interview with Certified Nurse Aide (CNA) #6, on 04/20/12 at 10:00 AM, revealed Resident #4 did not like to request assistance and frequently went to the bathroom unassisted. The alarm sounded on 03/18/12, but the resident was already up and trying to get to the bathroom by the time staff arrived. An interview with RN #4, on 04/20/12 at 1:45 PM, revealed Resident #4 was moved to a room closer to the nurse's desk	F 323		

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	185346	A. BUILDING _____ B. WING _____	04/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 323	Continued From page 20 on 03/18/12 to enable the facility staff to closely monitor the resident.The facility initiated an intervention for Resident #4 to be out in the lobby while up due to the resident removing alarms and hiding them in drawers. A review of the Plan of Care, dated 03/18/12, revealed interventions included to encourage Resident #4 to be in up in the lobby for observation and not to be left unattended while up in the wheelchair. A review of the "Fall/Change in Functional Status," dated 03/30/12, revealed a CNA found Resident #4 sitting in the floor of his/her room unattended. The resident stated he/she was trying to walk from the bathroom to the bedroom, reached for the door jam, missed it, and fell to the floor. The facility assessed for injuries and found a skin tear on the left elbow, as well as a complaint of hip pain. A review of the "Incident Accident Tracking Log," dated 03/30/12 at 6:30 PM, revealed Resident #4 was trying to go to the bathroom unassisted after he/she disconnected the alarms. An interview with CNA #8, on 04/19/12 at 3:00 PM, revealed the fall, on 03/30/12, occurred during the dinner meal while Resident #4 was in his/her room alone. CNA #8 described the routine for CNAs during mealtime was to "patrol" the hallway while residents ate meals in their rooms. She passed Resident #4's room and observed him/her sitting on the floor. The resident reported he/she reached for the door jam and fell backwards onto his/her bottom. An interview with RN #5, on 04/20/12 at 9:10 AM, revealed she was assisting in the dining room and was notified that Resident #4 fell. RN #5 returned to the unit after 10 minutes and found that the staff had assisted the resident to the	F 323		

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F 323	Continued From page 21 wheelchair, and he/she complained of hip pain. The physical assessment, completed at that time, revealed no obvious deformity and the resident was able to bear weight on his/her leg. RN #5 reported the staff informed her that the alarms sounded when Resident #4 fell and the staff arrived to his/her room to find him/her sitting on the floor. However, the facility did not identify Resident #4's care plan was not being followed as the resident was unattended in his/her room, was not in the lobby, and had alarms in place after they had been discontinued on 03/16/12. An intervention was added to keep the resident in the hallway while up in his/her wheelchair. A review of the Plan of Care, dated 03/30/12, revealed the interventions were updated to include a pressure alarm to the resident's wheelchair even though the facility had discontinued this intervention on 03/16/12 because the Resident #4 would disconnect and hide the alarms. A review of the physician's order, dated 03/30/12, revealed an authorization to x-ray Resident #4's left shoulder, left hip and left knee. A review of the nurse's note, dated 03/31/12 at 7:00 AM, revealed the x-ray results showed Resident #4 had a left hip fracture. The physician was notified and the facility transferred Resident #4 to the Emergency Room at 8:45 AM on 03/31/12. A review of the admission information, dated 04/06/12 at 6:00 PM, revealed Resident #4 was admitted to the facility after surgical repair of a left hip fracture which was sustained in the facility on 03/30/12. The facility continued to assess the resident at high risk for falls. Further review the	F 323		

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F 323	Continued From page 22 Interim Plan of Care, dated 04/06/12, revealed interventions included the bed was to be in the lowest position, a verbal reminder to not ambulate alone, assistance with transfers and ambulation as needed, observe for unsteady gait, dizziness, and intervene as needed, and pressure bed alarm and chair alarm. There were no documented interventions to address Resident #4's ability to remove the alarms or the need for increased supervision due to the resident's history of falls in the facility or recent fall resulting in a hip fracture requiring surgical repair. A review of the "Fall/Change in Functional Status," dated 04/16/12, revealed Resident #4 was found sitting on the floor of room and "seemed" to be working on his/her television with a metal rod from the wheelchair brake system. The physical assessment revealed no apparent injury was sustained. An interview with CMT #3, on 04/20/12 at 10:30 AM, revealed Resident #4 was found sitting on the floor in his/her room with the wheelchair behind him/her. The resident had the television remote in his/her hand and was "fiddling with it." It "appeared" the resident sat on the floor to work on the television in an attempt to quiet the alarms which were sounding. An interview with RN #5, on 04/20/12 at 9:10 AM, revealed she did not think the resident had fallen; however, the fall was unobserved so it must be treated as a fall. She believed Resident #4 thought the television made the alarm sound and worked on the television to make the alarm stop sounding. She stated Resident #4 was returned to the wheelchair and distracted with activities and left alone in the room.	F 323		

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F 323	Continued From page 23 A review of the Plan of Care for falls, dated 04/16/12, revealed an intervention for the resident to be in the lobby while up in the wheelchair as the resident was non-compliant with alarms. However, there was no documented evidence the facility addressed the alarm intervention. A review of the "Fall/Change in Functional Status," dated 04/17/12, revealed Resident #4 suffered two (2) falls within one hour to one and a half (1.5) hours. Resident #4 was found sitting on the floor with one elbow on the bed and one elbow on the seat of the wheelchair. The resident was assisted back to the wheelchair and the alarms were turned off. RN #5 transferred the resident back into the wheelchair and left the room to get equipment necessary for the post falls physical assessment. Resident #4 was left alone in his/her room at that time. An interview with RN #5, on 04/20/12 at 9:10 AM, revealed she believed the first unobserved incident on this date was a "true fall." Resident #4 was alone in his/her room when the chair and bed alarms sounded. RN #5 found the resident sitting on the floor, next to the bed, with one (1) elbow on the bed and one (1) elbow in the seat of the wheelchair. Resident #4 was returned to the wheelchair and RN #5 left the room to get assessment equipment. A review of the "Incident Accident Tracking Log," dated 04/17/12 at 2:30 PM, revealed "the resident was moving in bed and the pressure alarm went off. The resident tried to turn the alarm off and fell out of the bed." Interventions included to offer toileting, snacks or for the activities staff to spend one-to-one time with the resident.	F 323		

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F 323	Continued From page 24 Further review of the Fall/Change In Functional Status report, dated 04/17/12 revealed Resident #4 sustained a second fall at 4:00PM. RN #5 returned to the resident's room after leaving to obtain physical assessment equipment to find Resident #4 on his/her hands and knees on the opposite side of the bed. He/she was trying to pull the bed control cord from the bed frame. A review of the post falls physical assessment revealed no injuries. An interview with RN #5, on 04/20/12 at 9:10 AM, revealed RN #5 found Resident #4 on the opposite side of the bed, on hands and knees, trying to pull the bed control cord from the bed frame when she returned to the resident's room with the physical assessment equipment. RN #5 did not believe the second incident was a true fall because the resident was found on his/her hands and knees and pulling on the bed control cord. However, the resident was unattended and the fall was not observed which mandated the fall protocol be initiated. RN #5 stated the "alarms seem to agitate [him/her]." A review of the Incident Accident Tracking Log, dated 04/17/12 at 4:00 PM, revealed the resident was trying to go to bed unassisted and fell. Interventions included to apply geri sleeves, medications were reviewed, and the resident was started on anti-anxiety medication. There was no evidence the facility attempted to determine the root cause of the falls related to the information provided on the Incident Accident Tracking Log dated 04/17/12 compared to the information provided on the Fall/Change In Functional Status report. The Incident Accident Tracking Log listed the root cause of the incident as "Resident was	F 323		

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F 323	Continued From page 25 moving in bed, pressure bed alarm went off. Resident tried to turn off alarm and fell out of bed." Information provided by Resident #4's charge nurse at the time of the fall was documented on the Fall/Change in Functional Status report describing the resident was found sitting on the floor with one elbow on the bed and one elbow on the seat of the wheelchair. An interview with RN #5, on 04/20/12 at 9:10 AM, revealed Resident #4 was alone in his/her room when the chair and bed alarms sounded. RN #5 found the resident sitting on the floor, next to the bed, with one (1) elbow on the bed and one (1) elbow in the seat of the wheelchair. A review of the Plan of Care, dated 04/17/12, revealed an intervention was added to treat the resident's pain routinely. The facility did not implement any interventions related to falls prevention or resident safety, on 04/17/12, related to the falls sustained that day. On 04/18/12, an intervention was added to discontinue use of the Norvasc medication and initiate use of Lorazepam for anxiety. A review of the physician's order, dated 04/18/12, revealed a medication change from Norvasc (recommended for high blood pressure) to Ativan (recommended for anxiety) related to frequent falls. However, there was no evidence that the facility considered potential side effects of the drug change as the drug Ativan acts by slowing activity in the brain and may cause side effects to include drowsiness, dizziness, weakness, and shuffling gait. An interview with CNA #7, on 04/20/12 at 12:40	F 323		

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F 323	Continued From page 26 PM, revealed Resident #4 did not like the alarms and wanted to try to go to the bathroom alone. CNA #7 revealed the common occurrence of the resident leaning forward in the wheelchair caused the pressure chair alarm to sound, which agitated Resident #4. On 04/17/12, CNA #7 found Resident #4 in his/her room alone after the chair alarm sounded. CNA #7 revealed Resident #4 was taken for activities but would leave the activity and return to his/her room. Supervision after the falls included taking the resident out of the room while in the wheelchair and parking the resident's wheelchair at the nurse's station; however, he/she always wanted to return to the room, and was able to self-propel back to his/her room. An interview with CMT #3, on 04/20/12 at 10:30 AM, revealed her knowledge of the falls, on 04/17/12, came as a request from the Charge Nurse for pain medication indicating pain as the possible reason for Resident #4's agitation. CMT #3 stated she gave the pain medication Lortab 5/325 milligrams (mg) as requested by the Charge Nurse. An observation, on 04/18/12 at 11:40 AM, revealed Resident #4 was in bed with his/her eyes closed and was unattended. On 04/19/12 at 8:55 AM, the resident was returned to the room from physical therapy. He/she refused to be toileted and refused to go to bed. The resident stated he/she would rather be outside in the sun. The facility staff provided Resident #4 with activities on the over bed table	F 323		

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F 323	Continued From page 27 for easy reach and the table was on the right side of the resident's wheelchair. Afterward, the facility staff provided Resident #4 with activities and left the resident alone in the room. An observation, on 04/19/12 at 2:00 PM and at 2:30 PM, found Resident #4 lying in the bed unattended with his/her eyes closed. The personal body alarm was attached to the resident's clothing and the bed alarm activation light was blinking. An observation, on 04/20/12 at 11:55 AM, revealed Resident #4 was sitting in his/her wheelchair at the nurse's station. The resident was leaning forward, talking and gesturing with his/her hands and arms. An observation, on 04/20/12 at 1:30 PM, revealed Resident #4 was observed in the bed with a personal body alarm in place. The pressure bed alarm activation light was not blinking and the staff was notified. An observation, on 04/20/12 at 4:25 PM, revealed Resident #4 was sitting in his/her wheelchair in the doorway of his/her room in a forward drooped position with his/her eyes closed. The resident did not respond to a verbal greeting. An interview with CMT #3 revealed Resident #4 received Lortab 5/325 mg for pain at 11:00 AM, and received Ativan for anxiety at 12:00 PM. At 4:33 PM, Resident #4 remained in the wheelchair in the doorway of his/her room. His/her posture was more erect at that time. The resident responded to a verbal greeting by lifting his/her head and opening his/her "glassy" eyes. The resident's mouth fell open from a relaxed jaw, but no verbal	F 323		

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F 323	Continued From page 28 response was given. An interview with RN #5, on 04/20/12 at 9:10 AM, revealed Resident #4 was non-compliant with being in the hallway while out of the bed. He/she self-propelled down the hallway and out of sight. Resident #4 was taken to the television room to be with other residents on another unit of the facility at times. However, the resident self-propelled around the facility as desired. RN #5 stated she checked on Resident #4 about every hour or so. Interview with CNA #6, on 04/20/12 at 10:00 AM, revealed Resident #4 got "aggravated" with alarms and threw them across the room. Resident #4 did not want "the girls," meaning the CNAs, to take him/her to the bathroom and tried to go without assistance. CNA #6 reported the staff was suppose to keep an eye on him/her and make sure the resident was not trying to get up unassisted. The staff was to watch for indications of toileting needs, such as shuffling around, or restlessness. Resident #4 was usually taken to the television area on a different unit after meals and left without supervision. An interview with CMT #3, on 04/20/12 at 10:30 AM, revealed Resident #4 moved in and out of his/her room all the time while up in the wheelchair. CMT #3 stated the resident was to be visible at all times, and recalled Resident #4 being in the television room on another unit as recently as four (4) days ago, and self-propelled back to his/her room unassisted.	F 323		

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F 323	Continued From page 29 Interview with CNA #7, on 04/20/12 at 12:40 PM, revealed Resident #4 started going to the television room on another unit within the past week. The resident was unsupervised while in the television room. The staff assigned to Resident #4 relied on the staff from another unit when the resident traveled to the television room and called the nurses to alert them that the resident was going to the television room. CNA #7 specifically recalled the resident being in the television room unsupervised at 7:00 AM on the morning of 04/17/12. CNA #7 stated she was constantly looking for the resident as he/she was too quick and "you pretty much have to be there all the time." CNA #7 reported there was only one (1) CNA on the hallway when she worked and she could not keep the resident from going into his/her room, so she had to listen for the alarms. Interview with RN #4, on 04/20/12 at 1:45 PM, revealed the staff tried to keep Resident #4 in sight, but he/she was mobile and went to his/her room when he/she wanted to. RN #4 stated Resident #4 had no safety awareness and returned to his/her room where he/she was unsupervised. An interview with the DON, on 04/20/12 at 3:10 PM, revealed the facility had staffing to ensure adequate supervision was provided for Resident #4 to keep him/her safe. The DON stated if the nursing staff was busy, she could notify other facility departments, such as activities or the chaplain, to attend to the resident. The DON stated Resident #4 cannot be forced to stay at the nurse's station and the staff cannot keep the	F 323		

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F 323	Continued From page 30 resident on one-to-one supervision, as the staff had to take care of other residents. The DON reported the facility ensured the safety of Resident #4 the same way as they do for all residents by moving around the facility and ensuring whereabouts of the residents. Another method of ensuring safety, reported by the DON, was "team tackling" and described this method as part of internal audits and the review of different topics each day. However, the facility continued to use interventions of alarms which staff detailed agitated the resident. Furthermore, the facility specified the resident was not to be left alone in his/her room and to be up in the lobby, but the resident was consistently found in the room unattended and found on the floor and considered to have fallen, even after the resident experienced a hip fracture requiring surgical repair. Furthermore incidents reports continued to detail the resident was attempting to go to the bathroom unassisted with no documented evidence that the facility addressed new interventions to prevent the resident from attempting to go to the bathroom unassisted. 2. A record review revealed the facility admitted Resident #1 on 10/17/07 with diagnoses to include Cerebral Vascular Accident (CVA) with left-sided Hemiparesis and Psychoses with hallucinations. A review of the quarterly MDS assessment, dated 02/02/12, revealed the facility assessed Resident #1 as cognitively intact and he/she required minimal assistance of one staff for ambulation. A review of the Falls assessment, dated 02/02/12, revealed the facility assessed Resident #1 at high risk for falls.	F 323		

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F 323	Continued From page 31 A review of the Comprehensive Care Plan for falls, dated 02/06/12, revealed the facility developed interventions for Resident #1 to have a personal alarm on at all times while up in the wheelchair and a pressure alarm on while in the bed. A review of the Licensed Nurse Treatment Record, dated 04/12, revealed Resident #1 was suppose to have a personal alarm while up in the wheelchair and a pressure bed alarm on the bed at all times. A review of the CNA Treatment Record, dated 04/12 revealed Resident #1 was suppose to have a personal alarm while up in the wheelchair, and to check placement and function every shift, and for a pressure bed alarm, check placement and function every shift. Observations on 04/18/12 at 10:30 AM, 3:50 PM, 4:35 PM and 4:55 PM, and on 04/19/12 at 9:30 AM, 10:55 AM, 11:40 AM and 1:50 PM, revealed Resident #1 was up in the wheelchair with no alarm in place. Review Licensed Nurse Treatment Record revealed the licensed staff initialed the Treatment Record on 04/18/12 and 04/19/12 for both shifts (7A-7P and 7P-7A) indicating the alarm was in place and had been checked by the licensed staff. Further review CNA Treatment Record revealed CNAs indicated the alarm was in place and functioning on the Treatment Record on 04/18/12 and 04/19/12 for both shifts (7A-7P and 7P-7A). An observation and interview with LPN #1, on 04/19/12 at 10:10 AM, revealed Resident #1 was	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185346	A. BUILDING _____ B. WING _____	04/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

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F 323	Continued From page 32 In the wheelchair with no alarm on the wheelchair and when the nurse checked the resident's bed, there was no pressure alarm under the sheet on the mattress or an alarm box in place. She stated Resident #1 was suppose to have a clip alarm on his/her wheelchair and a pressure alarm on the bed. She was unable to provide an explanation as to why the alarms were not in place. She showed the surveyor the Licensed Nurse Treatment Record and stated the Licensed Nurse checked every shift to ensure his/her alarm was in place and signed. Interviews with CNA #4 and CNA #5, on 04/20/12 at 9:15 AM and 9:25 AM, respectively, revealed Resident #1 should have had a chair alarm and bed alarm in place, but they were unable to provide an explenation as to why the alarms were not in place. They were also unable to provide an explanation as the why the CNA treatment record was initialed indicating the alarms were in place on 04/18/12 and 04/19/12. Interviews with RN #1, RN #3, and Certified Medication Technician (CMT) #2 (who initialed alarms were in place on 04/18/12 and 04/19/12), on 04/20/12 at 10:35 AM, 10:40 AM and 11:00 AM, respectively, revealed when the licensed nurse initialed the treatment record next to the alarm orders, this indicated the alarms were in place and functioning. They were unable to provide an explanation as to why the treatment record was initialed, indicating the alarms were in place on 04/18/12 and 04/19/12. Interview with the DON, on 04/20/12 at 4:00 PM, revealed licensed staff and CNAs were suppose to check and ensure alarms were in place and	F 323		

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F 323	Continued From page 33 functioning every shift, and when care was provided for the residents. She stated the licensed treatment record and CNA treatment record was suppose to be initialed at the end of the shift to indicate the alarms were in place and functioning throughout the shift.	F 323		

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	185346	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1964, 1973, 1979 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF TYPE OF STRUCTURE: One (1) story, Type III Construction. SMOKE COMPARTMENTS: Seven (7) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system. GENERATOR: Type II, 35 KW generator. Fuel source is natural gas. A standard Life Safety Code survey was conducted on 04/19/12. Hermitage Care and Rehabilitation Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility is licensed for ninety-two (92) beds and the census was eighty-five (85) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: BEP | TITLE: Administrator | (X6) DATE: 5/14/12

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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	186346	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/19/2012

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at D level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility is licensed for ninety-two (92) beds and the census was eighty-five (85) on the day of the survey. The findings include: Observation, on 04/19/12 at 10:15 AM, with the	K 029	Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers it response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. 1. A self closing device was installed to the door of Medical Records on 05/03/12 by the facility Maintenance Director. 2. No residents were affected by the alleged deficient practice. The facility was evaluated for other deficient practice of self closing devices on 04/30/2012 by Maintenance Director. No other deficient practice was identified.	

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K 029	Continued From page 2 Maintenance Director revealed the door to the Medical Records Room, located near the Nurses Station in the E Hall, did not have a self closing device installed on the door. Interview, on 04/19/12 at 10:15 AM, with the Maintenance Director revealed he was not aware of the Medical Records Room being categorized as a hazardous storage area, and the requirement that the door be equipped with a self closing device. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2),	K 029	3. An in-service with the facility department heads was conducted by Maintenance Director on 05/7/2012 regarding the new self closing device installed to Medical Records door and the importance of this door remaining closed when not occupied. 4. Maintenance Director will conduct a daily audit for 5 days, then weekly for 4 week, then monthly for 3 months of Medical Records door to ensure the self closing device is functioning properly and door is not open when not occupied. 5. Findings will be reported daily for 5 days in the morning daily meeting and weekly in the morning daily meeting and monthly to the administrator for additional follow up and education as needed. The administrator will report the audit results to the monthly Quality Assurance meeting for three months for recommendations and follow up. 6. Corrective Action Date: 06/01/2012	6/1/12

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K 029	Continued From page 3 Including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff, and visitors. The facility is licensed for ninety-two (92) beds and the census was eighty-five (85) on the day of the survey. The findings include: Observation, on 04/19/12 at 12:05 PM, with the Maintenance Director revealed medical equipment (a Hydrocollator) located in the Rehab Manager ' s Office, was plugged into a standard	K 147	1. Maintenance Director installed a Ground Fault Circuit Interrupter outlet on 05/03/2012 in therapy department to be utilized for hydrocollator located in therapy department. 2. No residents were affected by the alleged deficient practice. The facility was evaluated by Maintenance Director on 04/25/2012 for other deficient practices of Ground Fault Circuit Interrupters. No other deficient practices were identified 3. An in-service with the therapy staff and facility management staff was conducted by Maintenance Director on 05/7/2012 regarding the install of the Ground Fault Circuit Interrupter outlet and the need for the hydrocollator to be plugged into this outlet.	

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K 147	Continued From page 4 electrical outlet, instead of a Ground Fault Circuit Interrupter (GFCI) outlet required in wet areas. Interview, on 04/19/12 at 12:05 PM, with the Maintenance Director revealed he was not aware of the requirement for the Hydrocollator (containing water) to be proteoted by plugging it into a (GFCI) outlet. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	4. Maintenance Director will conduct a weekly audit of hydrocollator to ensure it is plugged into the new Ground Fault Circuit Interrupter outlet and is functioning properly for 4 weeks then monthly for 3 months if no other deficient practices noted. Any deficient practice will be reported immediately to the therapy director and the facility administrator for follow up and further education to the department. 5. Weekly audits will be reported to the administrator in the daily morning meeting by the facility Maintenance Director for 4 weeks. Monthly audits will be reported to the monthly Quality Assurance meeting by the administrator for recommendations and follow up. 6. Corrective Action Date: 06/01/2012	6/1/12