

*acceptable POC 11/21/13 compliance date*  
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 12/29/13  
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/15/2013
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NAME OF PROVIDER OR SUPPLIER  KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102
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F 000	INITIAL COMMENTS  An Abbreviated Survey Investigating KY#00020934 was initiated on 11/14/13 and concluded on 11/15/13. KY#00020934 was unsubstantiated with unrelated deficiencies cited. Deficiencies cited with the highest Scope/Severity of "D".	F 000	Resident #2 was sent out to the hospital on 11/10/13, and was discharged to another facility on 11/12/13. The error was discovered during the compliant investigation conducted on 11/15/13.	11/21/13
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update	F 157	No type of corrective action was taken on resident #2 as the resident was not in the facility during the investigation. On 11/20/13 an audit was completed by the SLP, Sara Clemons and designee, Annie Bishop, rehab manager facility wide regarding the dietary supervision level changes. The corrective action accomplished is that all dietary supervision level changes were audited and all notifications are up to date and complete. No other errors were identified with dietary level supervision notifications to the families/POA. The facility will identify potential future residents by completing an audit during care plan meetings and focus meetings that prompt the SLP, Sara Clemons or designee, Annie Bishop, rehab manager to make the proper notification to families to all	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Keith Morgan* *ADMINISTRATOR* 12-16-13

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 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to notify the responsible party for a resident care change for one (1) of three (3) sampled residents (Resident #2). The facility failed to notify or inform Resident #2's Power of Attorney (POA) of a dietary supervision level change.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Family Notification" dated June 2003 revealed it was the policy of the facility to notify residents' family or POA in a timely manner if a significant change occurred in a resident's treatment.</p> <p>Record review revealed the facility admitted Resident #2 on 10/30/09, and re-admitted the resident on 09/07/13, with diagnoses which included Dementia, Pneumonia and Congestive Heart Failure. Review of the Speech Therapy Evaluation and Treatment Plan dated 08/22/13, revealed a diagnosis of Dysphagia (difficulty swallowing) which was noted to be a "new onset". Continued review revealed Resident #2 was at risk for Aspiration (inhaling food or fluid into the lungs) and Pneumonia and, was to have close supervision when eating. Continued record review revealed Resident #2 was discharged to the hospital where he/she was diagnosed with Pneumonia; Resident #2 returned to the facility and Speech Therapy was again ordered. Review of the Speech Therapy Evaluation and Treatment</p>	F 157	<p>The facility will ensure compliance with the entire regulation by having the SLP, Sara Clemons or designee Annie Blshop, rehab manager complete an audit on all charts regarding new supervision level changes resident charts during weekly focus meetings and weekly care plan meetings. All results will be reported in monthly QAPI meetings for a period of one year. The corrective measure put into place are an audit of dietary supervision level changes completed by SLP, Sara Clemons or designee, Annie Blshop, rehab manager in weekly focus and care plan meetings, as well as a facility wide education regarding notifications to responsible parties/ POA completed on 11/20/13, completed by Christy Penick, QA Nurse for all nurses and therapists. QAPI members include Keith Moore, Administrator, Lisa Queen, Assistant Administrator, Arlene Massie, DON, Pam Bryan, ADON, Phillip Fioret, Medical Director, Christle Penick, Quality/Staff Development/ Infection Control, Teria Maynard, MDS coordinator, Jo Ann Davis, MDS nurse, Terri Johnson,</p>	

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F 157	<p>Continued From page 2</p> <p>Plan dated 09/13/13, revealed diagnoses of Dysphagia and Dementia and, Resident #2 was to have close supervision when eating. Review of the ST Encounter Notes revealed Resident #2's Dysphagia improved and on 09/26/13, the resident was discharged from Speech Therapy with recommendations for occasional supervision.</p> <p>Interview with the ST on 11/15/13 at 2:10 PM, revealed Resident #2 was discharged from Speech Therapy and she usually notified the family/POA. She stated she did not document this notification and couldn't remember if she notified Resident #2's POA. She indicated the POA should have been notified of the change in supervision level.</p> <p>Interview with Resident #2's POA on 11/15/13 at 8:37 AM, revealed he had been informed the resident was to be continuous supervision level while eating meals. The POA stated he was never made aware that on 09/26/13, Resident #2 had been placed on occasional supervision and was discharged from Speech Therapy.</p> <p>Interview with the Director of Nursing (DON) on 11/15/13 at 4:30 PM, revealed Resident #2's POA, did not visit the facility often, although he wanted to be notified of "everything" She stated considering Resident #2's history of Aspiration, the POA should have been notified when Speech Therapy changed the supervision level to occasional and discharged the resident as per facility policy.</p>	F 157	<p>MDS nurse, Adam Rucker, Resident Services Director, Glenna Greenslade, Social Worker, Curtis Metzler, Cardiac Manager, Jennifer McFarlin, Human Resources, Kayleigh Ticknor, Registered Dietitian, Randy Payne, Environmental Manager, Gail Cunningham, Dietary Manager, Anthony Crance, Maintenance Supervisor, Vicky Baily, Medical Records, Annie Bishop, Rehab Manager, Susan Kempf, Resident Care Manager (RCM), Brian Neely, RCM, Violet Stewart, RCM, Pam Willis, RCM, Josie Armstrong, Transitional Navigator, Robin Bishop, Wound Care Nurse, Steve Bessler and Kathy Shaffer, Consultant Pharmacist, Dave Thomas, Finance Director. The quality nurse will monitor compliance through monthly QAPI meetings for one year or longer to ensure all dietary supervision level change notification are in complete and accurate.</p> <p>Resident #2 was sent out to the hospital on 11/10/13, and was discharged to another facility on 11/12/13. The error was discovered</p>
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	11/21/13

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F 279	<p>Continued From page 3</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:        Based on interview, record review and review of the facility's policy, it was determined the facility failed to develop a comprehensive plan of care for one (1) of three (3) sampled residents in regards to a diagnosis of Dysphagia.</p> <p>The findings include:        Review of the facility's policy titled, "Comprehensive Plan of Care", effective date December 2001 and revised date of November 2002, revealed it was the responsibility of each interdisciplinary team member involved in the resident care to provide input into the development, implementation, maintenance and</p>	F 279	<p>during the compliant investigation conducted on 11/15/13. No type of correction action was taken on resident #2 as the resident was not in the facility during the investigation. An audit was completed facility wide by RD, Kayleigh Ticknor on 11/20/13 regarding dysphagia diagnosis and care plans and no other errors were found. The corrective action accomplished is that all care plans for dysphagia diagnosis has been audited and are complete and accurate. The facility will identify future residents by completing the care plan notification and diagnosis check sheet during weekly care plan meetings. This will be completed for a period of one year by the RD, Kayleigh and the speech therapy department and findings reported in monthly QAPI meetings. The facility will ensure compliance with the entire regulation by having the MDS and Therapy Manager, Teria Maynard and Annie Bishop conduct random audits monthly and report findings in monthly QAPI meetings.</p>	

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F 279	<p>Continued From page 4</p> <p>evaluation of the residents's plan of care. Further review revealed, all staff who provided care should be knowledgeable of and have access to the resident's plan of care. Additional review revealed each resident was to have a Comprehensive Care Plan which was to be updated quarterly, annually and whenever significant changes occurred.</p> <p>Record review revealed the facility admitted Resident #2 on 10/30/09, and re-admitted the resident on 09/07/13, with diagnoses which included Dementia, Pneumonia and Congestive Heart Failure. Review of the fourteen (14) day Minimum Data Set (MDS) Assessment dated 09/25/13, revealed the facility assessed Resident #2 to have no swallowing disorders. Review of the Speech Therapy Evaluation and Treatment forms dated 08/22/13 and 09/08/13 revealed Resident #2 had been diagnosed with Dysphagia. Review of the Comprehensive Care Plan dated 05/08/13, revealed no documented evidence of a care plan to address Resident #2's diagnosis of Dysphagia.</p> <p>Interview with the Speech Therapist on 11/15/13 at 2:10 PM, revealed 08/22/13 was the first Dysphagia diagnosis.</p> <p>Interview with the Licensed Practical Nurse (LPN) #5 on 11/15/13 at 2:15 PM, who completed MDS assessments, revealed nurses performed the assessments and reported to her. She stated she then completed the MDS Assessments in the computer. According to LPN #5, "adjustments" were made to the care plan after each residents' care plan meeting. She indicated Resident #2's Comprehensive Care Plan should have included a care plan for the resident's diagnosis of</p>	F 279	<p>This will be conducted monthly for a period of one year.</p> <p>The corrective measures put into place are an audit conducted in weekly care plan meetings by the speech therapists or dietitian as well as a random audit completed by the MDS and/or Therapy coordinators monthly and report all findings in the facilities monthly QAPI meetings. A facility wide education regarding care planning for dysphagia were completed on 11/20/13 by Christy Penick, QA nurse for all nurses and therapists. QAPI members include Keith Moore, Administrator, Lisa Queen, Assistant Administrator, Arlene Massie, DON, Pam Bryan, ADON, Phillip Fioret, Medical Director, Teria Maynard, MDS Coordinator, Christie Penick, Quality/Staff Development/Infection Control, Jo Ann Davis, MDS Nurse, Terri Johnson, MDS Nurse, Adam Rucker, Resident Services Director, Glenna Greenslade, Social Worker, Arinn McKnight, Admissions, Jennifer McFarlin, Human Resources, Curtis Metzler, Cardiac Manager, Kayleigh</p>

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F 279	<p>Continued From page 5 Dysphagia.</p> <p>Interview with the Dietician on 11/14/13 at 3:15 PM, revealed she thought it was more of Speech Therapy's responsibility ensure the Comprehensive Care Plan Included Dysphagia care plans. She stated she did not consider this to be her responsibility. According to the Dietician, she had never included Dysphagia diagnoses on her Nutrition care plan. Further interview revealed the Dietician did not attend residents' care plan meetings.</p> <p>Interview with the Director of Nurses (DON) on 11/15/13 at 4:30 PM, revealed she would have "thought" the Dysphagia care plan would of been put on there by nursing. Further interview revealed the Comprehensive Care Plan should have been updated to include the Dysphagia diagnosis. She indicated Dietary should be doing the care plan.</p>	F 279	<p>Ticknor, Registered Dietitian, Randy Payne, Environmental Manager, Gail Cunningham, Dietary Manager, Anthony Crance, Maintenance Supervisor, Vicky Baily, Medical Records, Annie Blshop, Rehab Manager, Susan Kempf, Resident Care Manager (RCM), Brian Neely, (RCM), Violet Stewart, (RCM), Pam Willis, (RCM), Josie Armstrong, Transitional Navigator, Robin Blshop, Wound Care Nurse, Steve Bessler and Kathy Shaffer, Consultant Pharmacist, Dave Thomas, Finance Director.</p> <p>The quality nurse will monitor compliance through monthly QAPI meetings for one year or longer to ensure all dysphagia diagnosis on care plans.</p>	