

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

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FORM APPROVED
OMB NO. 0938-0391

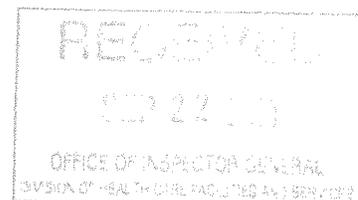
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER HARDINSBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143		
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F 329	Continued From page 20 were responsible for completing documentation on the medical record regarding the targeted behaviors and the interventions implemented. The DON further revealed nurses were responsible for monitoring and documenting the side effects of antipsychotic medications. The DON stated she was sure the nurses had tried different behavior interventions, but had not documented. She stated she looked at the nurses notes with the Assistant Director of Nursing (ADON) every morning and educated the nurses on correct documentation. The DON did not provide verification of the nurses' training she had conducted. The DON stated she needed to provide more education to the nursing staff on resident behavior monitoring and interventions.	F 329			
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425 1.	Resident #9 PRN psychotropic medication was De'd on 8/28/14. AIMS testing was complete on resident #9 by the Assistant Director of Nursing on 9/17/14. Resident # 2 had a GDR of Risperdal and diagnosis of psychosis with irritability behavioral system given on 09/12/14 as well as on 9/8/14 medication of Paxil was changed to Lexapro per Pharm. Recommendation. Risperdal to be discontinued on 9/26/14 for	10/1/14	



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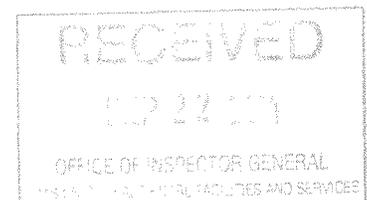
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F 425	<p>Continued From page 21</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, Pharmacy Consultant Services Policy, Pharmacy Participation in Facility's Quality Assurance Meetings/Committees Policy, and the Consultant Pharmacy Recommendations, it was determined the facility failed to ensure antidepressant, antipsychotic, and psychotropic medication concerns were addressed or collaborative efforts for reduction was in place by pharmacy services for three (3) of sixteen (16) sampled residents (Residents #2, #9, and #11).</p> <p>The findings include:</p> <p>Review of the Pharmacy Consultant Services Policy, effective 01/01/12, revealed the facility should provide an opportunity for entrance and exit interviews between Pharmacy and Director of Nursing, Administrator, or designee.</p> <p>Review of the Pharmacy Participation in Facility's Quality Assurance Meetings/Committees policy, revised 09/01/12, revealed the pharmacy staff will participate in QA meetings in the extent provided in the Pharmacy Services Agreement. The Pharmacy representative may be the Consulting Pharmacist or other designated Pharmacy staff member as permitted by Applicable law. The Pharmacy staff cannot attend</p>	F 425	<p>resident # 2. Resident #11 GDR complete on 9/3/14 order to DC AM dose of Risperdal. On 08/28/14 the Consultant Pharmacist attended the facility</p> <p>1. QA meeting to present and review psychotropic medication and recommendation follow up to the QA committee.</p> <p>2. On 08/28/14 the Consultant Pharmacist attended the facility QA meeting to present and review psychotropic medication and recommendation follow up to the QA committee. An audit of all residents with psychotropic medications will be completed by the Social Services Director by 09/30/14 to identify any resident on psychotropic medications without GDR, without behavior monitoring or without appropriate Dx. Any identified resident will be immediately corrected.</p> <p>3. By 09/30/14 the Pharmacy General Manager will provide re-education to the consultant Pharmacist on the requirement to participate in the facility Quality Assurance Committee at least quarterly as well as to track and trend psychotropic medication use and</p>	



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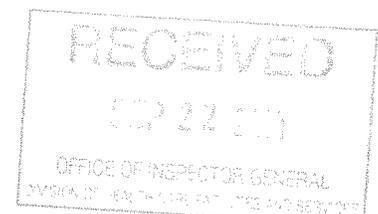
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F 425	Continued From page 22 the QA meeting, Pharmacy may provide the appropriate information to support the facility's QA meeting agenda, and or may conference into the meeting by phone. The Consulting Pharmacist or Pharmacy representative will present quality assurance reports to the Committee at least quarterly that include, but are not limited to; Pharmacy Quality of Assurance Reports, Psychopharmacological Medication, Drug Utilization Reports and an overview of Pharmaceutical care and pharmacy services. Review of the Consultant Pharmacist recommendations for Resident #2, on 05/23/14, revealed a request for the reduction in the dose of Risperdal on 06/16/14, revealed to another request for consideration of the reduction of the Risperdal dosage and to give specific diagnosis indications as to why to continue Risperdal and on 07/23/14, revealed to consider discontinuation of Paxil and changing to an alternative therapy such as Lexopro, that it has to be a valid therapeutic intervention for the continued use, to monitor for irregular heartbeat, shortness of breath, dizziness and fainting and should be reported immediately. Review of Consultant Pharmacist recommendations for Resident #9, dated 02/12/14, revealed a recommendation to discontinue an as needed (PRN) order for Risperdal and monitoring for signs and symptoms of involuntary movement for Resident #9. Review of Consultant Pharmacist recommendations for Resident #11, on 02/12/14, revealed to consider reducing the dose of Risperdal and on 05/23/14, revealed to please consider a gradual dose reduction for Risperdal	F 425	GDR and follow up with recommendations and report findings to the facility Quality Assurance Committee. Pharmacist will meet monthly upon exit with Dir. Of Nursing, Administrator and Social Services to review pharmacy recommendations. Pharm Recs are delivered to the MDs to review by Medical Records. Signed recommendations should be returned within 72 hours. Dir. of nursing will follow up with MD if we do not have orders returned within specified time frame. Once returned Dir. of Nursing or Assistant Dir. of Nursing will review all completed pharmacy recommendations before placed in charts. 4. The Pharmacy Supervisor will audit ten pharmacy recommendations/reviews per month for three months to assure the pharmacy consultant is reviewing and making appropriate recommendations with follow through from previous recommendations. The DON will audit ten resident records per month for six months to assure that the pharmacy recommendations are		



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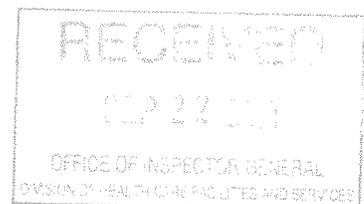
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F 425	<p>Continued From page 23 at night.</p> <p>Interview with the Consultant Pharmacist, on 08/21/14 at 10:40 AM, revealed she visited the facility monthly to conduct resident medication reviews. The pharmacist revealed the frequencies of her psychoactive medication GDR recommendations were based upon the resident's diagnosis, response to medications, and the incidence of behaviors. The pharmacist revealed while she was not involved with the facility interdisciplinary team (IDT) meetings; she did talk with the Director of Nursing (DON) regarding particular concerns going on with residents. She further revealed she had not recently attended any facility Quality Assurance (QA) meetings due to staff changes. She stated she had last attended a facility QA meeting six (6) months ago, but had reviewed QA reports with the DON or Administrator. She revealed the Consultant Pharmacist was responsible for collaborating resident care with the Medical Director of the facility. The pharmacist revealed the QA meetings allowed for the collaboration of resident care, including discussing concerns and recommendations with the physician to improve quality of care.</p> <p>Further interview with the Consulting Pharmacist, on 08/21/14 at 11:15 PM, revealed she was aware she was to meet at least quarterly with the QA to make changes and to monitor. The Consulting Pharmacist stated she wanted to improve the quality of care for the residents and inform the doctors as to why she wanted to make changes to medications. The Consulting Pharmacist stated she was aware there were a lot of residents with dementia on psychotropic medications and she was aware of the new</p>	F 425	<p>reviewed timely with appropriate response and follow up. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least six months or until the committee deems resolved. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at a minimum, the Director of Nursing, the Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director and Pharmacy Consultant attending at least Quarterly.</p>	



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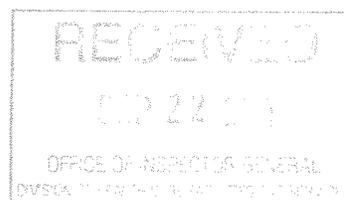
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F 425	<p>Continued From page 24</p> <p>changes that suggested decreasing psychotropic medications with the dementia residents. The Consulting Pharmacist stated she was not helping the facility to identify, evaluate and address medication issues that may affect the residents medical care and quality of life because she was not following through to ensure the recommendations were addressed, nor was she collaborating with the physicians to ensure the recommendations were evaluated. The Consulting Pharmacist stated she followed up with the Director of Nursing, but did not follow up with the Physicians.</p> <p>Interview with Social Services, on 08/21/14 at 2:53 PM, revealed the staff went over the new orders in morning meetings, but did not go over the recommendations. Social Services stated the Consulting Pharmacist had not attended the Quality Assurance (QA) meetings in the last year. There was a meeting about a year ago, with the Physicians, in which the Physicians stated they did not agree with the recommendations and the Consulting Pharmacist was not present.</p> <p>Interview with the Director of Nursing (DON), on 08/21/14 at 4:31 PM, revealed it was important for the Pharmacy Consultant to attend the meetings because we do not want to harm the residents. The DON stated she read the recommendations from the Consulting Pharmacist and looked to see if the recommendations had been changed. The DON stated there was a system failure as it pertained to psychotropic medications in the facility. There was no follow through from the Consulting Pharmacist, Doctors and Nursing Staff.</p> <p>Interview with the Medical Director, on 08/21/14</p>	F 425			



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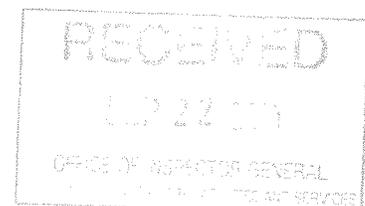
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F 425	Continued From page 25 at 4:04 PM, revealed he was not familiar with the new Consulting Pharmacist and that she had not attended any of the QA meetings. The Medical Director also stated he was not familiar with the new guidelines for reducing anti-psychotics with Dementia residents and if the Consulting Pharmacist would have informed him of the new changes he would have agreed with the new initiative. The Medical Director stated he liked to utilize Risperdal for confusion and irritability. He further stated if the nursing staff called in regards to a resident being agitated he would probably increase the Risperdal dosage. Interview with the Administrator, on 08/21/14 at 5:10 PM, revealed the Consulting Pharmacist or the pharmacy recommendations had to be present during the QA meetings. The Consulting Pharmacist had not attended QA meetings and when the Administrator attended the QA meetings, the recommendations were not addressed. The Administrator stated no one was responsible for oversight of the Pharmacy recommendations. The Administrator stated she was responsible to ensure the recommendations were being addressed and followed through.	F 425		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	1. Residents # 3, 5, 8, 12, 13's DNR form was reviewed with the appropriate individual and witness signature obtained by Social Service Director by 9/30/14. Resident # 8 does not currently have an order for IM Ativan as noted by the Director of Nursing on 8/25/14. LPN # 3 was re-educated by the Director of Nursing on 9/12/14 on the requirement to document on the	10/1/14



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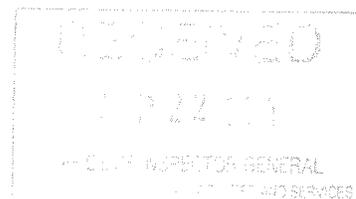
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F 514	<p>Continued From page 26</p> <p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and the Emergency Medical Services (EMS) Do Not Resuscitate (DNR) Order form, it was determined the facility failed to maintain complete and accurate clinical records for five (5) of sixteen (16) sampled residents (Resident #3, #5, #8, #12 and #13). The facility failed to obtain two (2) witness signatures as required for Residents #3, #5, #12 and #13 as it related to the EMS DNR Order form. In addition, the facility failed to document whether a controlled medication was administered to Resident #8.</p> <p>The findings include:</p> <p>A policy could not be provided by the facility; however, review of the EMS DNR Order form, revealed in lieu of having this form notarized, it may be witnessed by two (2) persons not related to the individual noted above.</p> <p>1. Record review of Resident #5's EMS DNR Order, revealed the notary and two (2) witness lines were not signed or notarized, though the signature for the Power of Attorney was signed on 04/17/13 to initiate the order.</p> <p>Interview with Registered Nurse (RN) #1, on 08/21/14 at 3:39 PM, revealed most of the time</p>	F 514	<p>MAR if a medication was given or not given.</p> <p>2. Audit of the buildings DNR forms will be completed by 09/30/14 by Social Service Director. Any residents found with a request for a DNR and lacking two witnesses will have new DNR forms signed and witnessed by 9/30/14. An observation by the Director of Nursing on 9/12/14 noted that medications were being documented appropriately and if not given documented appropriately.</p> <p>3. Education on the proper way to complete the DNR forms including two witnesses was given to staff that complete the DNR forms to include Admissions, Social Services and Nursing Administration on 9/8/14 by the Administrator. All Licensed Nurses to be educated by 09/30/14 by the Director of Nursing or Assistant Director of Nursing as to the proper way to document whether a medication was administered and to obtain two witness signatures on the EMS DNR form.</p>		



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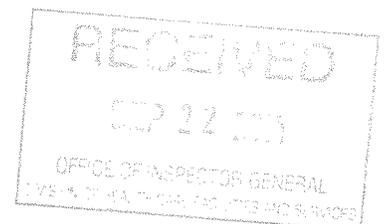
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F 514	<p>Continued From page 27</p> <p>the Admission and Marketing Director completed the EMS DNR order form, but sometimes as a nurse, she filled the form out. RN #1 stated when she completed the form she never obtained two (2) witness signatures and could not remember the last time she had to complete the EMS DNR Order form. RN #1 stated Resident #5's form did not look complete. RN #1 stated she had no problems with EMS taking residents in an emergent situation, but theoretically if the form was not completed, EMS may provide Cardiopulmonary Resuscitation (CPR) to the resident against their wishes.</p> <p>Interview with the Admission and Marketing Director, on 08/21/14 at 3:45 PM, revealed she completed the EMS DNR Order form. The Admission and Marketing Director stated that Social Services monitored the form yearly. The Admission and Marketing Director stated Resident #5's form did not look complete because it was not filled out with two (2) witnesses or had a notary completed. The Admission and Marketing Director stated when she filled out the form she usually signed as one of the witnesses but never obtained a second witness. The Admission and Marketing Director stated the form could be a problem because their wishes may not be addressed.</p> <p>Interview with Social Services, on 08/21/14 at 2:53 PM, revealed she would complete resident admissions, for the Admission and Marketing Director, if she was absent and would complete the EMS DNR Order forms in the admission packet. Social Services stated when she would fill out the form she would not obtain two (2) witness signatures. Social Services stated she reviewed the EMS DNR Order form during quarterly care</p>	F 514	<p>4. The Administrator will audit 5 residents a month for six months to ensure the DNR EMS forms are being completed accurately. The Director of Nursing or Assistant Director of Nursing will audit MARs weekly for twelve weeks to assure that the nurses have documented administration or not administered medications. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least six months or until the committee deems resolved. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at a minimum, the Director of Nursing, the Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director and Pharmacy Consultant attending at least Quarterly.</p>		



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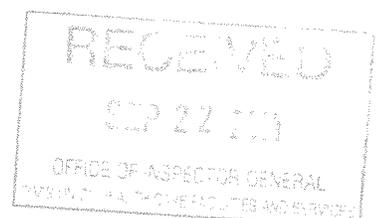
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F 514	<p>Continued From page 28</p> <p>plan meetings and when she reviewed the EMS DNR Order form, she would only review to see the Person/Legal Surrogate's Signature was signed. Social Services stated Resident #5's EMS DNR Order form was not notarized or signed by two (2) witnesses. Social Services stated she had had no concerns with EMS services at the facility, but after reviewing Resident #5's EMS DNR Order form she felt the form was not complete and Resident #5's wishes may not be honored by EMS services.</p> <p>2. Review of the clinical record for Resident #3 revealed the resident was admitted to the facility on 12/13/13. Further review of the clinical record revealed the Kentucky Emergency Medical Services (EMS) Do Not Resuscitate (DNR) Order form for Resident #3 had been signed by the resident's Power of Attorney (POA) on 12/30/08 to initiate the DNR order; however, the form had not been notarized or signed by witnesses.</p> <p>3. Review of the clinical record for Resident #13 revealed the resident was admitted to the facility on 07/01/12. Further review of the clinical record revealed the EMS DNR Order form for Resident #13 had been signed by the resident's POA on 03/02/13, but had not been notarized or signed by witnesses.</p> <p>4. Review of the medical record for Resident #12 revealed the facility admitted the resident on 10/22/13 with Diagnosis including Dementia and Psychosis.</p> <p>Review of the Kentucky Emergency Medical Services DNR order revealed the Healthcare Surrogate signed three (3) different forms, dated 09/23/13, 10/04/13 and 10/22/13. None of the</p>	F 514	



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F 514	Continued From page 29 forms were notarized and only one (1) had one (1) witness. Interview with the Admissions and Marketing Director on 08/21/14 at 10:07 AM revealed she was responsible for getting the Emergency Service form signed but did not know if was not notarized there had to be 2 witnesses. She stated the potential complications were the EMS might not honor the Do Not Resuscitate. Interview with the Director of Nursing (DON), on 08/21/14 at 3:55 PM, revealed the Social Services Director was responsible for ensuring all residents' admission packets, including the Kentucky EMS DNR Order forms, were signed and complete. The DON further revealed she was not conducting audits on the residents' clinical records to verify they were accurate and complete. 5. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 07/01/12 with diagnoses of Pneumonia, Urinary Tract Infection, Chronic Airway Obstruction, Congestive Heart Failure, Depressive Disorder, Anxiety, and Dementia. Further review of the clinical record revealed a physician order, dated 08/06/14, for the one-time administration of Ativan 2 mg intramuscular (IM) stat for agitation. Review of the resident's Medication Administration Record (MAR) for the month of August 2014 revealed a handwritten entry for Ativan 2 mg/ml give 2 mg IM X (1) dose. The handwritten order did not indicate the date the order was received from the physician or the date the medication was to be administered. Review of the MAR revealed the one-time Ativan order had not been signed off by the nurse indicating	F 514			



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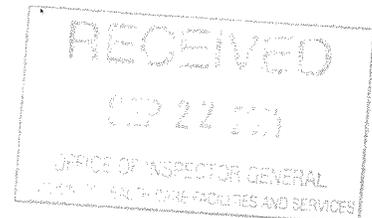
PRINTED: 09/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER HARDINSBURG NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143
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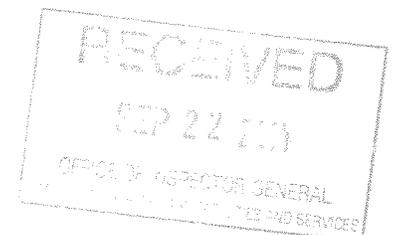
F 514	<p>Continued From page 30</p> <p>the medication had been administered per the physician's order. Review of Resident #8's Controlled Substance Proof of Use form for the Ativan revealed the nurse had not signed out the ordered dose of medication. Review of the nurses' note for Resident #8 revealed there was no documentation indicating whether the Ativan had or had not been administered to the resident.</p> <p>Interview with LPN #3, on 08/20/14 at 3:25 PM, revealed she had notified the Nurse Practitioner on 08/06/14 of Resident #8's agitation. The LPN revealed she had received a telephone order for Ativan 2 mg IM X 1 dose. The nurse further revealed she had transcribed the Ativan order to the resident's MAR. The LPN stated she should have specified the exact date of the order on the MAR by writing in a "block" for August 6. LPN #3 also stated she should have entered her initials and circled them indicating the medication had not been given. The nurse revealed she did not document in the nursing notes that the Ativan had not been administered to Resident #8. The LPN revealed she had made a late entry to the resident's clinical record on 08/20/14 documenting the Ativan had not been administered. LPN #3 revealed the Assistant DON was responsible for checking and verifying accuracy of all physician orders daily, including transcription of those orders to the MAR's.</p> <p>Interview with the Director of Nursing (DON), on 08/20/14 at 3:55 PM, revealed she had not noticed the missing documentation on the MAR, or nurses notes, for the one-time Ativan order written 08/06/14. The DON revealed she looked at nurses notes every morning and educated staff on correct documentation, but could not provide documentation of the training. She revealed the</p>	F 514		
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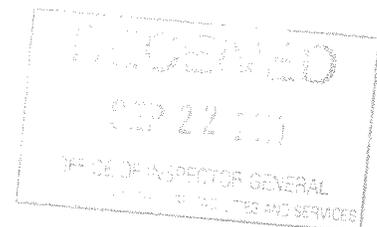
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F 514	Continued From page 31 current process for monitoring and verifying medication orders and MAR's was not working. The DON stated there needed to be a different system in place to verify all physician orders were transcribed correctly. She also stated there was a need for additional staff training regarding documentation.	F 514			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520	1. The Pharmacy Consultant attended monthly QA on 8/28/14 and reviewed psychotropic medication trends and recommendations as noted by the Administrator on 08/28/14. 2. The Pharmacy Consultant attended monthly QA on 8/28/14 and reviewed psychotropic medication trends and recommendations as noted by the Administrator on 08/28/14 3. By 09/30/14 the Pharmacy General Manager will provide re-education to the consultant Pharmacist on the requirement to participate in the facility Quality Assurance Committee at least quarterly as well as to track and trend psychotropic medication use and GDR and follow up with recommendations and report findings to the facility Quality	10/1/14	



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F 520	<p>Continued From page 32</p> <p>by: Based on interview, record review, Quality Assurance (QA) Policy, the Pharmacy Participation in Facility's Quality Assurance Meetings/Committee Policy, the Monthly QA Meeting Sign in Sheet and the list of Dementia Residents on Anti-psychotic medications, revealed the facility failed to develop and implement appropriate plans of action as it related to pharmacy recommendations and psychotropic medications.</p> <p>The findings include:</p> <p>Review of the Quality Assurance Policy, revised 09/2013, revealed all residents will be assessed at least on admission, quarterly, and with change of condition per Interact III system for any additional or new needs noted. All changes will be communicated with the IDT, Responsible Party, Physician, and in the medical record of that resident according to the systems adopted. All residents will be assessed for risks and baseline condition including but not limited to psychotropic medication use. The policy did not outline who would attend the QA meetings.</p> <p>Review of the Pharmacy Participation in Facility's Quality Assurance Meetings/Committees policy, revised 09/01/12, revealed pharmacy staff would participate in QA meetings in the extent provided in the Pharmacy Services Agreement. The Pharmacy representative may be the Consulting Pharmacist or another designated Pharmacy staff member as permitted by Applicable law. The facility should notify the Pharmacist, as far in advance as possible of the dates and times of upcoming QA meetings. If the Pharmacy staff cannot attend the QA meeting, Pharmacy may</p>	F 520	<p>Assurance Committee. The Regional Director of Operations will educate the QA committee by 9/30/14 to ensure the facility understands how to identify quality deficiencies and how to develop a plan of action to prevent potential deficient practice from occurring. This includes but is not limited to contract services, resident needs, employee satisfaction, internal systems and trends and patterns.</p> <p>4. The Administrator will review Pharmacy Quality Assurance reports quarterly for at least one year to assure that the Pharmacy is including tracking and trending of psychotropic medications, recommendations and GDR Quality. The Regional Director of Operations will attend at least one Quality Assurance Committee meeting Quarterly for one year to assure that the facility's QA committee is reviewing systems, contract services and resident/employee satisfaction in a manner that identifies concerns and develops plans to correct as well as review current plans of correction for effectiveness of plans. The reviews will be reviewed by the</p>



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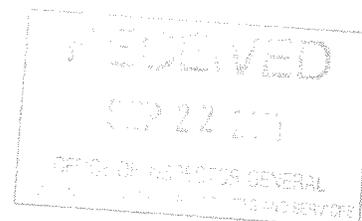
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F 520	Continued From page 33 provide the appropriate information to support the facility's QA meeting agenda, and/or may conference into the meeting by phone. The Consulting Pharmacist or Pharmacy representative will present Quality Assurance reports to the Committee at least quarterly that include, but are not limited to; Pharmacy Quality of Assurance Reports, Psychopharmacological Medication, Drug Utilization Reports and an overview of Pharmaceutical care and pharmacy services. Review of the Monthly QA Meeting sign-in sheet, revealed QA meetings on 12/19/13, 01/30/14, 02/27/14, 03/27/14, 04/24/14, 05/22/14, 06/26/14, and 07/24/14 in which a Consultant Pharmacist was not in attendance. Review of the list of Dementia Residents with Psychotropic medications, revealed thirteen (13) residents were administered psychotropics in the past month. Interview with Social Services, on 08/21/14 at 2:53 PM, revealed the Consulting Pharmacist had not attended the Quality Assurance (QA) meetings in the last year. Social Services stated that a couple of weeks ago she made the wrong mistake and told the Consultant Pharmacist the wrong date, thus the Consulting Pharmacist did not attend. There was a meeting about a year ago, with the Physicians, in which the Physicians stated they did not agree with the recommendations and the Consulting Pharmacist was not present. Interview with the Director of Nursing (DON), on 08/21/14 at 4:31 PM, revealed it was important for the Pharmacy Consultant to attend the	F 520	Quality Assurance Committee quarterly for at least twelve months or until the committee deems resolved. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The committee will consist of at a minimum, the Director of Nursing, the Administrator, Assistant Director of Nursing, Dietary Services Manager, Social Services Director with the Medical Director and Pharmacy Consultant attending at least Quarterly		



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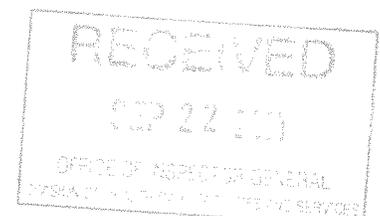
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F 520	<p>Continued From page 34</p> <p>meetings because she did not want the residents to be harmed. The DON stated she read the recommendations from the Consulting Pharmacist and looked to see if the recommendations had been changed. The DON stated she felt there was a system failure as it pertained to psychotropic medications in the facility. There was no follow through from the Consulting Pharmacist, Doctors and Nursing Staff. The DON stated she would look to see if the recommendations were changed, if the recommendations were not changed, the recommendations were filed into the residents chart. If a recommendation was changed, she would report this information in the morning meeting. The DON stated she did not take the recommendations into the QA meetings.</p> <p>Interview with the Consulting Pharmacist, on 08/21/14 at 11:15 PM, revealed she attempted to go to QA meetings within the last six (6) months, but the facility kept changing the dates of the meetings. The Consulting Pharmacist stated she had not met with the Medical Director to voice her concerns and risks with Psychotropic medications. The Consulting Pharmacist stated she was aware she was to meet quarterly to improve the quality of care and to inform the Medical Director of why she was making medication changes.</p> <p>Interview with the Medical Director, on 08/21/14 at 4:04 PM, revealed he was the Medical Director of the facility and never missed a QA meeting. The Medical Director stated the Consulting Pharmacist used to come for every QA meeting and would talk about psychotropic medications. The Medical Director stated he was not familiar with the new guidelines as it pertained to</p>	F 520	



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F 520	Continued From page 35 psychotropic medications and dementia patients. He was not familiar with the new Consulting Pharmacist and did not realize it had been that long since he had seen a Consulting Pharmacist at the QA meetings and further stated the Consulting Pharmacist needed to be present at the QA meetings. The Medical Director stated he recommended and felt the QA team needed to come up with a plan on how to address Dementia residents and the use of Psychotropic drugs. Interview with the Administrator, on 08/21/14 at 5:10 PM, revealed she had attended the QA meetings. The Administrator stated she knew the Consulting Pharmacist could either attend the QA meetings or send reports through Social Services. The Administrator stated Social Services would bring a report to the meeting on how many residents were on psychotropics in the building, but not the recommendations from the Consulting Pharmacist. The Administrator further stated, no one informed her about how important it was to have the Consulting Pharmacist present in the QA meetings and to have pharmacy recommendations in the QA meetings.	F 520			



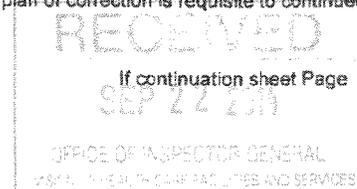
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1967, 1991 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (000) SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system; hydraulically designed. GENERATOR: Type II, 55 KW generator; fuel source is propane gas; installed new in 2009. A recertification Life Safety Code survey utilizing the 2786S short form, was conducted on 08/20/14. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has sixty- three (63) certified beds and the census was fifty-seven (57) on the day of the survey. The findings that follow demonstrate	K 000	Submission of this is plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest again the facility, the Administrator or any employees, agents, or other individual who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements. 1. On 8/21/14 the Maintenance Director sealed the openings in the interior walls and ceiling in the sprinkler riser room with fire rated sealant.	10/1/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Juven Powers* TITLE: *Administrator* (X6) DATE: *9/19/14*

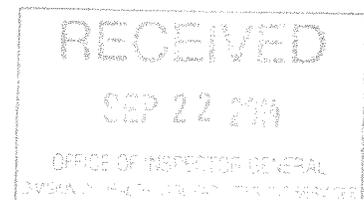
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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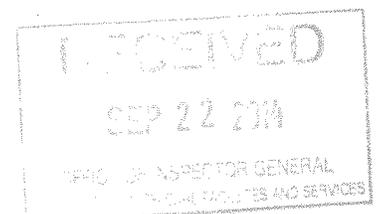
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at "D" level.	K 000	2. Maintenance Man will audit all areas with the potential to have an opening to ensure they are patched and sealed with fire rated sealant and the room is able to resist the passage of smoke. Any identified will be corrected by 9/30/14.		
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 National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty-three (63) certified beds and the census was fifty-seven (57) on the day of the survey. The findings include:	K 029	3. The Maintenance Director was re-educated by the administrator on 9/12/14 regarding the need for all openings to be patched and sealed with fire rated sealant and to audit any vendor work. Maintenance Dir. will audit any vendor work after completion to ensure no openings were left. 4. The Maintenance Director will audit all areas for potential openings to assure they are capable of resisting the passage of smoke in the event of an emergency. This audit will be completed on a monthly basis for 6 months. Maintenance Dir. will audit all vendor work after completion to ensure no openings are left. The results of the audits will be reviewed monthly by the Quality Assurance Committee until team concludes issues are resolved. If at any time concerns are identified the Quality Assurance Committee		



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K 029	Continued From page 2 Observation, on 08/20/14 at 10:02 AM, with the Administrator and the Maintenance Director revealed the Sprinkler Riser Room had openings in the interior walls and ceiling where the sprinkler pipes were located. The openings had not been patched and sealed with a fire rated sealant and the room was not capable of resisting the passage of smoke in the event of an emergency. Interview, on 08/20/14 at 10:04 AM, with the Administrator and the Maintenance Director revealed they were not aware the pipe penetrations of the interior drywall and ceiling were not patched and sealed with a fire rated sealant. They acknowledged the room was not smoke-tight and capable of resisting the passage of smoke into the attic space in the event of an emergency. The census of fifty-seven (57) was verified by the Administrator, on 08/20/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/20/14. 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	K 029	will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HARDINBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143	
(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
K 029	Continued From page 3 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), 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		

