

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

PRINTED: 11/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. BUILDING _____	(X3) DATE SURVEY COMPLETED C 09/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MAPLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 GREENE DRIVE GREENVILLE, KY 42345	
(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 --AMENDED-- An abbreviated survey (Complaint #KY23809) was initiated on 09/22/15 and concluded on 09/23/15. This was a Minimum Data Set (MDS) 3.0 Staffing Focus Survey. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	This amended 2567 was received from the OIG on 11/12/15. The alleged date of compliance reflects newly added tags that were not on the original 2567 and does not reflect the building's inability to achieve substantial compliance within the 45 day post exit window.	11/13/15
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *James H. ...* TITLE: Executive Director (X6) DATE: 11/13/15

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 278	<p>Continued From page 1 material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Resident Assessment Instrument User Manual Version 3.0, it was determined the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for two (2) of ten (10) sampled residents related to a fall and skin issues (Resident #5 and Resident #8).</p> <p>The findings include:</p> <p>1. Record review revealed the facility admitted Resident #8 on 05/17/12 with diagnoses that included Alzheimer's Disease, Anxiety State, Hypertension, and Schizoaffective Disorder Unspecified.</p> <p>Review of the MDS 3.0 Manual, Section M1040, pages 29 and 30, dated October 2011, revealed the facility should review a resident's medical record, including skin care flow sheets or other skin tracking forms, and check all other ulcers, wounds, and skin problems that applied in the last seven (7) days. The skin conditions included item M1040H Moisture Associated Skin Damage (MASD).</p> <p>Review of the Quarterly MDS assessment, with an assessment reference date (ARD) of 08/13/15, revealed the facility did not check item M1040H for Resident #8, indicating the resident did not have Moisture Associated Skin Damage. However, review of a Skin Inspection Anatomy Diagram dated 08/07/15 revealed Resident #8</p>	F 278	<p>1) The following corrective action was accomplished for residents #5 and #8: A modified quarterly assessment was completed for resident #8 was completed by the MDS coordinator on 9/23/15 to reflect the moisture associated skin dermatitis. A modification of the admission 5 day assessment was completed for resident #5 by the MDS Coordinator on 9/23/15 to reflect the fall.</p> <p>2) Residents that have the potential to be affected by the same deficient practice will be identified by an audit of MDS section M1040H and section J1900 that have been completed in the past 90. This audit will be conducted by the RN Case Manager & the MDS Coordinator to ensure that any falls and/or skin conditions that have occurred in the past 90 days are correctly coded to the MDS. The audit will be completed by 10/16/2015.</p> <p>3) The measure used to ensure the practice will not recur, was an education provided to the MDS Coordinator and the Case Manager by the Director of Nursing Services on 9/23/15 (DNS). The education provided addressed the need to review weekly skin audit forms, weekly pressure and non-pressure assessments, treatment records, fall assessments, and nurses notes to gather information to ensure accurate coding of the MDS assessments.</p> <p>4) The facility plans to monitor that performance solutions are maintained by having the Case Manager audit 2 MDS assessments weekly for 90 days to ensure continued accurate coding of the MDS assessments. Any concerns will be immediately reported to the DNS. In addition, audits will be reviewed by the PI Committee monthly for 3 months.</p>	11/13/15	

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F 278	<p>Continued From page 2</p> <p>had MASD to his/her coccyx. In addition, review of a Physician's Order dated 08/06/15 revealed to apply a thin layer of cornstarch to the pad under his/her buttocks twice a day.</p> <p>Interview with the MDS Coordinator on 09/23/15 at 10:35 AM revealed she usually looked at the medical record upon completion of an MDS and reviewed the Nurse's Notes, Treatment Administration Records (TAR), and the weekly skin assessments. She stated she was not sure how she missed coding the MASD for Resident #8.</p> <p>Interview with the Director of Nursing (DON) on 09/23/15 at 9:45 AM revealed she expected the MDS to be completed accurately and reflect the resident's condition.</p> <p>2. Record review revealed the facility admitted Resident #5 on 07/16/15 with diagnoses that included Dysphagia, Chronic Pain Syndrome, Methicillin Resistant Staph Aureus (MRSA) in a coccyx wound, Type II Diabetes Mellitus, Polyneuropathy in Diabetes, Hypertension, Hypothyroidism, Hyperlipidemia, Gout, Unspecified Psychosis, Depressive Disorder, and Hypertrophy Prostate.</p> <p>Observation of Resident #5 on 09/22/15 at 9:30 AM revealed he/she was lying in bed with an indwelling catheter to bedside drainage.</p> <p>Review of the MDS 3.0 Manual, Section J1900, page J-32, dated April 2012, revealed coding instructions for J1900 A, fall with no injury, were to Code 1 "if the resident had one non-injurious fall since admission/entry or reentry or prior assessment."</p>	F 278			

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F 278	Continued From page 3 Review of a five-day MDS assessment dated 07/21/15 revealed under Section J1900 (Falls) the facility documented Resident #5 had not sustained any falls since admission. However, review of Nurse's Notes dated 07/19/15 revealed Resident #5 had an unwitnessed fall, and was observed on the floor, lying on his/her right side with the right arm bent under his/her head. The resident reported (per Nurse's Notes) he/she was getting up to get ready to go to work. Interview with the MDS Coordinator on 09/22/15 at 2:06 PM revealed falls were discussed during facility morning "stand up" meetings and the resident's fall not being coded on the MDS assessment was an oversight on her part. Interview with the Executive Director on 09/23/15 at 10:02 AM revealed he expected a fall to be captured during the seven-day look period of an MDS assessment, and if it was not captured, the MDS should be modified to accurately reflect the coding.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279			

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F 279	<p>Continued From page 4</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 facility policy and procedure, it was determined the facility failed to ensure a Comprehensive Care Plan was developed for the use of an antidepressant medication (Cymbalta) for one (1) of ten (10) sampled residents (Resident #2). Resident #2's physician placed the resident on Cymbalta sixty (60) milligrams (mg) on 10/20/14; however, the facility failed to develop a care plan to address the use of Cymbalta.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Care Plans," dated 01/07/12, revealed a comprehensive care plan was developed consistent with the resident's specific conditions, risks, needs, behaviors, preferences, and standards of practice. The policy stated the care plan would include measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in the resident's assessment or as identified in relation to the resident response to the interventions or changes in the resident's condition.</p>	F 279	<p>1) The following corrective action was completed for resident #2: The Mood Care Plan was revised by the MDS Coordinator on 11/9/15 to include "administration of medication as ordered by the physician."</p> <p>2) Residents that have the potential to be affected by the same deficient practice will be identified by audit. An audit of care plans for residents receiving antidepressant medications was concluded on 11/11/15 by the MDS Coordinator to ensure that the care plans reflect the "administration of medications as ordered by the physician."</p> <p>3) The measure used to ensure that the practice will not recur was providing education to the licensed nurses. Education was provided to the licensed nurses by the Staff Development Coordinator on the development and revision of care plans for residents receiving antidepressant medication to include the "administration of medication as ordered." This education was completed on 11/12/15.</p> <p>4) The facility plans to monitor that performance solutions are maintained through review of new orders for antidepressant medications by the Director of Nursing Services (DNS) and/or the Unit Managers (UMs) on the next business day to ensure that the "administration of the medication" nomenclature has been added to the care plan. The DNS will audit two orders against the care plans weekly for 3 months, if orders have been received, to ensure ongoing compliance. Audits will then be reviewed monthly by the PI Committee.</p>	11/13/15	

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F 279	Continued From page 5 Record review revealed the facility admitted Resident #2 on 10/20/14 with diagnoses that included Depressive Disorder, Chronic Pain, Hypertension, and Edema. Review of the September 2015 Physician's Order for Resident #2 revealed an order for Cymbalta 60 mg every day for Depression. The medication was initiated on 10/20/14. Review of the Comprehensive Care Plan dated 09/12/14, and last revised 10/23/15, revealed a mood care plan related to the diagnosis of Depression; however, the care plan did not address the resident's use of Cymbalta. Interview with the Case Manager on 11/05/15 at 11:17 AM revealed this was the only care plan written related to Resident #2's depression. Interview (post survey) with the Case Manager on 11/09/15 at 3:15 PM revealed the Charge Nurse was responsible to ensure a care plan was developed for the use of Cymbalta for Depression. Interview with Unit Manager #1 on 11/05/15 at 9:07 AM revealed she expected nursing staff to ensure the care plan was developed to reflect the resident's status. Interview with the Executive Director on 11/05/15 at 9:05 AM revealed he expected nursing staff to follow the interventions on the care plan and to develop the care plan as needed.	F 279			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329			

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F 329	<p>Continued From page 6</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure one (1) of ten (10) sampled residents was free from unnecessary drugs (Resident #3).</p> <p>Pharmacy Recommendations dated 03/10/15 and 05/07/15 to decrease the resident's Cymbalta from sixty (60) milligrams (mg) to thirty (30) mg once a day were signed by the physician; however, the facility failed to ensure the order was transcribed to a Physician's Order which</p>	F 329	<p>1) The corrective action taken immediately to address the effected resident was to call the Physician for resident #2. He was contacted by the Charge Nurse on 9/22/15 to report the error. The physician's recommendation was given at that time which was to continue the Cymbalta at 60mg as originally ordered, and not to reduce as the missed pharmacy recommendations order reflected.</p> <p>2) The facility will identify other residents that have the potential to be affected by the same practice. An audit of the consultant pharmacist recommendations for medication changes made in the past 90 days was completed by the Unit Managers and the Director of Nursing to ensure that the order has been transcribed and followed as ordered by the physician. Completion date of the audit 10/19/2015.</p> <p>3) The measure put into place to ensure that the deficient practice will not recur was to provide education to the licensed nursing staff on 10/15/15 by the Staff Development Coordinator on Policy #4.4 "New Orders for non-controlled substances." emphasizing that pharmacy recommendations are to be forwarded to the physician for his reply/order and then transcribed in the computerized order entry portal (if an order has been changed) or given prior to placing the recommendation in the residents chart.</p> <p>4) The facility plans to monitor ongoing compliance by having the Unit Managers and/or the DNS audit a sample of 6 pharmacy recommendations monthly for 90 days to ensure compliance with the orders given by the physician. If there are concerns identified, they will be reported to the DNS (if the audit was conducted by someone other than the DNS) as well as the physician for correction. Finding of the audits will be reviewed by the PI Committee monthly for 3 months.</p>	11/13/15	

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F 329	<p>Continued From page 7</p> <p>resulted in Resident #2's dose not being reduced and the resident receiving twice the recommended dose of Cymbalta every day for approximately fifty-nine (59) days.</p> <p>The findings include:</p> <p>Review of the facility policy titled "New Orders for Non-Controlled Substances," last revised 01/01/13, revealed once the Physician/Prescriber signed a new order for an existing resident, an interim order form or telephone order form should be completed.</p> <p>Record review revealed the facility admitted Resident #2 on 10/20/14 with diagnoses that included Depressive Disorder, Chronic Pain, Hypertension, and Edema.</p> <p>Review of a signed Pharmacy Recommendation dated 03/10/15 revealed to decrease Resident #2's Cymbalta from 60 mg once a day to 30 mg once a day; however, review of the Physician Orders revealed the order was never written to decrease the medication dosage.</p> <p>Further review revealed another signed Pharmacy Recommendation, dated 05/07/15, to reduce the Cymbalta 60 mg to 30 mg daily; however, further review of the Physician Orders revealed the order was never written to decrease the medication.</p> <p>Review of the June 2015 through September 2015 MAR revealed the resident received Cymbalta 60 mg every day which resulted in the resident receiving twice the recommended dose for a total of 59 days.</p>	F 329			

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F 329	Continued From page 8 Interview (post survey) with the Registered Nurse (RN), Unit Manager #1, on 11/09/15 at 3:30 PM revealed the Charge Nurse working the unit was responsible for writing Physician Orders from the Pharmacy Recommendations.	F 329			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy, it was determined the facility failed to ensure pharmacy recommendations were acted upon for one (1) of ten (10) sampled residents (Resident #2). Resident #2 had Pharmacy Recommendations dated 03/10/15 and 05/07/15 to decrease the resident's Cymbalta	F 428			

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F 428	<p>Continued From page 9</p> <p>from sixty (60) milligrams (mg) to thirty (30) mg once a day; however, the facility failed to ensure the Pharmacy Recommendations approved by the Physician to decrease the dosage were acted upon. This failure resulted in Resident #2 receiving a double dose of the recommended dose of Cymbalta every day for approximately fifty-nine (59) days.</p> <p>The findings include:</p> <p>Interview (post survey) with the Director of Nursing on 11/09/15 at 2:55 PM revealed at the time of the survey pharmacy recommendations went to the DON, she reviewed the recommendations, and then the recommendations requiring new orders were taken to the physician's office for his/her signature. After the physician signed the recommendation, a new order was to be written by the Unit Manager or the Charge Nurse for the change in the medication and the order was entered into the computerized medication administration software, which transferred onto the Medication Administration Record (MAR) for administration.</p> <p>Record review revealed the facility admitted Resident #2 on 10/20/14 with diagnoses that included Depressive Disorder, Chronic Pain, Hypertension, and Edema.</p> <p>Review of the Pharmacy Recommendations dated 03/10/15 and 05/07/15 revealed the Pharmacist recommended a gradual dose reduction in Resident #2's Cymbalta from 60 mg to 30 mg daily. Further review revealed the Primary Care Physician had signed both requests as "agreed" with the recommendations.</p>	F 428	<p>1) The corrective action taken immediately to address the effected resident was to call the Physician for resident #2. He was contacted by the Charge Nurse on 9/22/15 to report the error. The physician's recommendation was given at that time which was to continue the Cymbalta at 60mg as originally ordered, and not to reduce as the missed pharmacy recommendations order reflected.</p> <p>2) The facility will identify other residents that have the potential to be affected by the same practice. An audit of the consultant pharmacist recommendations for medication changes made in the past 90 days was completed by the Unit Managers and the Director of Nursing to ensure that the order has been transcribed and followed as ordered by the physician. Completion date of the audit 10/19/2015.</p> <p>3) The measure put into place to ensure that the deficient practice will not recur was to provide education to the licensed nursing staff on 10/15/15 by the Staff Development Coordinator on Policy #4.4 "New Orders for non-controlled substances." emphasizing that pharmacy recommendations are to be forwarded to the physician for his reply/order and then transcribed in the computerized order entry portal (if an order has been changed) or given prior to placing the recommendation in the residents chart.</p> <p>4) The facility plans to monitor ongoing compliance by having the Unit Managers and/or the DNS audit a sample of 6 pharmacy recommendations monthly for 90 days to ensure compliance with the orders given by the physician. If there are concerns identified, they will be reported to the DNS (if the audit was conducted by someone other than the DNS) as well as the physician for correction. Finding of the audits will be reviewed by the PI Committee monthly for 3 months.</p>	11/13/15	

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MAPLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 GREENE DRIVE GREENVILLE, KY 42346		
(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 428	<p>Continued From page 10</p> <p>However, review of the Physician's Orders revealed there was no order to decrease Resident #2's Cymbalta from 60 mg to 30 mg on 03/10/15 or on 05/07/15.</p> <p>Review of March through September 2015 MARs revealed Resident #2 received 60 mg of Cymbalta, which was twice the dose, for approximately 59 days.</p> <p>Interview with the Director of Nursing (DON) on 09/17/15 at 10:45 AM revealed the usual procedure was to bring the Pharmacy Recommendation back to the Unit Manager, and the Unit Manager or a Charge Nurse would write the order. Further interview (post survey) with the DON on 11/09/15 at 4:40 PM revealed she depended on the Charge Nurse and Unit Manager to ensure the order was written. She stated the only process in place at the time to ensure the approved pharmacy recommendation orders were written was for the Pharmacist to have identified that the dose reduction had not been completed per the approved Pharmacy recommendation during the next month's Pharmacy review.</p> <p>Interview (post survey) with the current Pharmacist on 10/26/15 at 8:06 AM revealed she would have expected Resident #2's Cymbalta dosage to have been reduced if the physician agreed with the recommendations for dose reductions and signed the recommendation for the medication dosage change. She stated the recommendations were made by the previous Pharmacist; however, she was aware of the situation with Resident #2.</p> <p>Interview (post survey) with the Primary Care</p>	F 428			

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

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F 428	Continued From page 11 Physician on 11/09/15 at 9:45 AM revealed he signed the pharmacy recommendations with the intent of the medication to be reduced to 30 mg per the Consultant Pharmacist's recommendations.	F 428			