

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 226	Continued From page 117 Agency.  23. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation stating care plan conferences would include any abuse, neglect or misappropriation concerns that the families or residents may have.  Interview with the DON on 08/01/14 at 10:00 AM, revealed all care plan conferences would include questioning residents and families about any concerns related to abuse, neglect or misappropriation.  24. Interview with the Administrator on 08/01/14 at 11:46 AM, revealed Corporate Administrative oversight of the facility was to continue until the immediacy was removed, then would continue weekly for four (4) weeks and then monthly.  25. Interview on 08/01/14 at 11:46 AM with the Administrator confirmed there would be a weekly QA meeting to include Corporate oversight weekly for four (4) weeks, then monthly and the last meeting was 07/26/14. He stated during the meeting they would discuss the audits and recommendations for frequency of continued audits related to the deficiencies cited.	F 226			
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	F 276	F276  Immediate Corrective Action for Residents Found To Be Affected  ♦ MDS has been completed on August 13, 2014 for resident #28.		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3578 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 276	<p>Continued From page 118</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of facility policy, it was determined the facility failed to ensure Minimum Data Set (MDS) Assessments were completed within three (3) months of the most recent clinical assessment for one (1) of thirty-seven (37) sampled residents (Resident #28).</p> <p>The facility completed a Quarterly MDS Assessment with an Assessment Reference Date (ARD) of 03/26/14; however, they failed to complete a subsequent MDS Assessment within ninety-two (92) days as required.</p> <p>The findings include:</p> <p>Review of the "Resident Assessment Instrument (RAI) User Manual Version 3.0", Chapter (2), Section (5), revealed the ARD must be within ninety-two (92) days after the ARD of the previous Assessment.</p> <p>Review of Resident #28's medical record revealed the resident had diagnoses which included Anemia, Heart Failure, Hypertension, Urinary Tract Infection, Seizure Disorder, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly MDS Assessment with an ARD date of 03/26/14, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) score of seven (7), which indicated the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for bed mobility, transfers, and locomotion on and off the unit. Continued review of the MDS revealed the facility</p>	F 276	<p><b>Identification of Other Residents with the Potential to be affected</b></p> <ul style="list-style-type: none"> <li>◆ The MDS schedule has been utilized to audit on August 12, 2014 to make sure all MDSs have been completed and submitted by the MDS coordinators by the SCC and CRS.</li> </ul> <p><b>Measures taken to assure there will not be a Recurrence</b></p> <ul style="list-style-type: none"> <li>◆ Education was completed on August 08, 2014 by Clinical Reimbursement Specialist (CRS) to MDS coordinators related to the RAI chapter 2 section 5 related to MDS completion schedules?</li> <li>◆ Beginning September 12, 2014 the CRS will monitor remotely (M-F) via <i>IHN/MDS software which provides facility specific MDS information via restricted portal access</i> to assure MDSs completed timely with report weekly to DON and Administrator with <i>re-education and/or disciplinary action as required up to and including termination</i>. This will continue until instructed otherwise by QA Committee.</li> </ul>		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 276	<p>Continued From page 119</p> <p>assessed the resident as requiring limited assist of one (1) staff for the following: ambulation in the room, dressing, eating, toilet use, personal hygiene and bathing. Further review revealed there was no documented evidence of subsequent MDS Assessments for review.</p> <p>Interview, on 07/26/14 at 1:35 PM, with Registered Nurse (RN) #1 who was the MDS Coordinator for the South Unit, revealed she had started in the position on 06/28/14. She stated she was under the impression the MDS Assessment which were due to be completed in June 2014 were already completed by Licensed Practical Nurse (LPN) #1, (the previous MDS Coordinator for the South Unit). She stated she was informed by LPN #1 who had also given her a calendar with the MDS Assessments listed which were due for July 2014 when she started the position. Continued interview revealed there must have been a miscommunication between LPN #1 and herself due to the change in positions. Further interview revealed she needed to complete a Significant Change MDS for Resident #28 and she did not realize it was due until she was informed by the Surveyor the previous day, 07/25/14. She stated the first time she had noticed the MDS Assessments, which were due to be completed in June 2014, were late was last week.</p> <p>Interview, on 07/26/14 at 2:00 PM, with LPN #1 revealed she had been the MDS Coordinator for the South Unit until 07/03/14. She stated there was a schedule of MDS Assessments which were due and she had opened the MDS Assessments which were to be done for June 2014. She further stated she had given RN #10 the list of MDS Assessments due in June 2014, and told</p>	F 276	<p>Monitoring Changes to Assure Continuing Compliance</p> <ul style="list-style-type: none"> <li>Beginning August 06, 2014, the Administrator or DON will report all findings weekly x 4 and then monthly ongoing to the QA committee to determine further need for continued education, revision of plan and process improvements.</li> </ul> <p>Date of Completion: 09-27-14</p>	
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 276	Continued From page 120 her the Assessments had been opened in order for her to finish them. She stated the MDS ARD for Resident #28 was 06/26/14 and the MDS Assessment would be late fourteen (14) days past 06/26/14.	F 276			
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 material and false statement.  This REQUIREMENT is not met as evidenced	F 278	F 278  <b>Immediate Corrective Action for Residents Found To Be Affected</b>  ♦ Resident #11 MDS was reviewed by the MDSN on August 13, 2014 for accuracy. Upon chart review did not meet RAI guidelines for coding as UTI infection. Resident #13 weight corrected to reflect accurate weight on MDS on July 03, 2014 by the MDSN.  <b>Identification of Other Residents with the Potential to be affected</b>  ♦ 100 % audit to assure all residents weight were accurately coded on most recent MDS and any corrections needed was completed on August 07, 2014 by CRS. Any residents with any MDS completed August 01, 2014 to September 03, 2014 has been reviewed by the SCC on September 03, 2014 to determine if the resident had a diagnosis of UTI the MDS was coded to accurately reflect it. Any concerns with MDS coding were modified as necessary.		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 278	<p>Continued From page 121</p> <p>by: Based on observation, interview, record review, review of the Minimum Data Set (MDS) Manual and review of the facility's policy, it was determined the facility failed to ensure the MDS Assessment was accurate for two (2) of thirty-seven (37) sampled residents (Residents #11 and #13).</p> <p>Resident #11 experienced a Urinary Tract Infection (UTI) during the assessment period; however, the UTI was not coded on the MDS Assessment. Additionally, Resident #13's weight was coded incorrectly on the most recent MDS Assessment.</p> <p>The findings include:</p> <p>Review of the MDS Manual, dated October 2011, revealed Item I2300 Urinary Tract Infection (UTI) had a look-back period of thirty (30) days for active disease instead of seven (7) days. Staff was to code only if all the following were met: the Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist or other authorized licensed staff as permitted by state law diagnosed a UTI in the last thirty (30) days.</p> <p>1. Review of Resident #11's medical record revealed the facility admitted the resident on 06/27/13, with diagnoses which included Hypertension, Diabetes, Senile Dementia and Delusion. Review of Resident #11's Quarterly MDS, dated 04/10/14, revealed the facility assessed the resident as being severely impaired.</p> <p>Continued record review revealed a Nurse's Note, dated 11/15/13, which stated Resident #11 had</p>	F 278	<p>Measures taken to assure there will be not be a recurrence:</p> <ul style="list-style-type: none"> <li>◆ Education completed August 08, 2014 by CRS to MDSN related to accuracy of coding on the MDS. <i>double checking assessments before they are filed to check for the need for modification. CRS stressed that the MDSN must read through each section of the MDS assessment prior to closing it to ensure accurate coding.</i></li> <li>◆ Beginning August 11, 2014 Administrator, DON, ADON, SDC, WCN or MDSN (<i>audit each other's work not their own</i>) will audit weekly the MDS that have been completed for that week x 4 weeks to validate accuracy of coding by comparing MDS to the clinical record and timeliness of transmission via review of the MDS Transmission Exception Report which indicates any late assessments.</li> <li>◆ After the 4 weeks of review the DON, ADON, SDC, WCN or MDSN will then audit 10% sample of MDSs to monitor for accuracy and timeliness monthly, until directed otherwise by the QA Committee.</li> <li>◆ Beginning September 12, 2014, CRS will monitor assessments via IHN/MDS software which provides facility specific MDS information via restricted portal weekly x 12 weeks to assure continued compliance with timeliness. Report of monitoring to be reported to the Quality Assurance Committee for any recommendations.</li> </ul>	

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 278	<p>Continued From page 122</p> <p>been found on the floor and was alert with some confusion. Review of the Physician's Telephone Order, dated 11/18/13, revealed an order to obtain a Urine Analysis (UA) with Culture and Sensitivity for Resident #11. Record review revealed Resident #11's urine was obtained and sent to the laboratory (lab). The lab's final report dated 11/21/13, revealed Resident #11 was noted to have Escherichia Coll (E-coll) in his/her urine. Record review revealed the Physician was notified on 11/21/13, and ordered Macrobid (an antibiotic) 100 milligrams (mgs) by mouth every twelve (12) hours for seven (7) days. However, review of Resident #11's Annual MDS, dated 12/21/13, revealed Section I, was not coded for the resident having had a UTI in the last thirty (30) days.</p> <p>Interview, on 07/02/14 at 4:38 PM, with MDS Coordinator #3, for the North Unit, revealed the MDS Coordinators were responsible for coding the MDS Assessments correctly. MDS Coordinator #3 reviewed Resident #11's medical record, and stated if the resident had been diagnosed with a UTI, he/she would have had to have been diagnosed with the UTI after the date of 11/02/13 for Section I of the MDS to be coded for that diagnosis. She stated as Resident #11 was diagnosed with a UTI on 11/21/13, he/she should have been coded on the 12/21/13 MDS, in Section I for having had a UTI within the past thirty (30) days.</p> <p>2. Review of the MDS Manual, dated October 2011, revealed Item K0200, Height and Weight had a look-back period of thirty (30) days for the items. Staff was to check the medical record for weights and enter the weight taken within the last thirty (30) days. Continued review revealed if a</p>	F 278	<p><b>Monitoring changes to assure continuing compliance:</b></p> <ul style="list-style-type: none"> <li>Beginning August 13, 2014 the DON will present all results from audits to QA weekly x4 and then monthly ongoing for any further recommendations and or resolutions.</li> </ul> <p>Date of compliance <b>09-27-14</b></p>		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 278	<p>Continued From page 123</p> <p>resident's weight was taken more than once during the preceding month; staff should enter the most current weight.</p> <p>Review of Resident #13's record revealed the facility admitted the resident on 06/27/13, with diagnoses which included Obesity, Chronic Pain and Gastric Diverticulum. Review of Resident #13's Annual MDS, dated 11/19/13, revealed under Section K, the resident was coded to have a weight of one hundred and ninety-four (194) pounds, with no weight loss or weight gain. Resident #13 was assessed to be moderately cognitively impaired.</p> <p>Observation of Resident #13, on 07/02/14 at 3:24 PM, revealed Resident #13 was observed to be physically obese, lying on the bed with the television on.</p> <p>Review of Resident #13's medical record revealed the resident was coded on the Quarterly MDS, dated 04/11/14, under Section K to have a weight of only fourteen (14) pounds with no weight loss or gain.</p> <p>Interview with MDS Coordinator #7, for the South Unit, on 07/03/14 at 5:16 PM, revealed Resident #13's weight was coded incorrectly on his/her Quarterly MDS Assessment, dated 04/11/14. She reported the resident's weight should have been documented as one hundred and ninety-four (194) pounds on the Quarterly MDS Assessment.</p> <p>Interview with the Director of Nursing (DON), on 07/03/14 at 5:20 PM, revealed it was her expectation for MDS staff to code residents' MDS Assessment correctly. The DON stated if an MDS was not correct, then staff should compete</p>	F 278			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 278	Continued From page 124 a modification of the MDS.	F 278			
F 279 SS=E	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.  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).  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Resident Assessment Instrument (RAI) Manual 3.0 Version, and review of facility's policy, it was determined the facility failed to develop a Comprehensive Plan of Care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for six (6) of thirty-seven (37) sampled residents (Residents	F 279	F 279  Immediate corrective action for residents found to be affected:  ♦ Comprehensive care plans to include measureable objectives and time tables to meet residents medical and nursing mental and psychosocial needs identified in the comprehensive assessment have been completed by the Interdisciplinary Team (IDT), for resident #26, #16,#30, #31,#24, #14 from July 26 to August 25, 2014.  Identification of other residents with the potential to be affected:  ♦ 100% audit of resident current medical record has been completed on July 29, 2014 to ensure that the comprehensive care plans to include measureable objectives and time tables to meet residents' medical and nursing mental and psychosocial needs identified in the comprehensive assessment have been completed by the IDT that includes the DON, ADON, Licensed Nurses, MDSN, CRS and SCC. With comprehensive care plans updated accordingly July 29 to September 125, 2014.		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 125 #14, #16, #24, #26, #30, and #31).</p> <p>Resident #14's Comprehensive Care Plan was not developed related to communication and psychotropic medications, although the Minimum Data Set (MDS) Care Area Assessments (CAAs) triggered for those areas.</p> <p>In addition, review of the Comprehensive Plans of Care for Resident #16, #24, #26, #30 and #31 revealed the Care Plans were not developed to include specific interventions related to how many staff was required and/or how often the resident was to be toileted; receive incontinence care; be turned and repositioned; or, be transferred in order for staff to provide the care indicated as required on the Comprehensive Assessment.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Planning-Interdisciplinary Team (IDT)", revised 10/13, revealed the care plan was based on the resident's comprehensive assessment and was developed by the IDT and should include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. The Interdisciplinary Process included identifying problem areas and their causes, and developing interventions that were targeted and meaningful to the resident.</p> <p>Review of the Resident Assessment Instrument Version 3.0 Manual (section 4.1) revealed 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</p>	F 279	<p>Measures taken to assure there will not be a recurrence:</p> <ul style="list-style-type: none"> <li>◆ Education has been completed for the MDSN, ADON, SSD, QoLD, and DSM related to policies and procedures for comprehensive care plans completed by the CRS on August 26, 2014.</li> <li>◆ Beginning September 1-22, 2014, the DON, ADON, SDC, WCN or MDSN will audit weekly the Care Assessment Areas (CAAs) completion and comprehensive care plans that have been completed for that <i>the previous</i> week x 4 weeks to validate completion and accuracy. <i>This will include observation and interviews with residents with BIMS 8 and above.</i></li> <li>◆ After the 4 weeks of review the DON, ADON, SDC, WCN or MDSN will then audit 10% sample of CAAs and comprehensive care plans to monitor for completeness and accuracy monthly. This will continue until instructed otherwise by the QA Committee.</li> <li>◆ Beginning September 8, 2014 the DON, ADON, SDC, WCN or MDSN will review care plans as necessary at the daily (M-F) clinical meeting to initiate, review and/or revise care plans as needed for change of conditions.</li> </ul>		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 126</p> <p>assessment. Further review of the Manual (section 4.4) revealed facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs. The process focuses on evaluating these triggered care areas using the (Care Area Assessments ) CAAs, but does not provide exact detail on how to select pertinent intervention for care planning. Interventions must be individualized and based on applying effective problem solving and decision making approaches to all of the information available for each resident. Section 4.7 states in selecting interventions and planning care, the key task would be to identify specific symptomatic and cause specific interventions for physical, functional, and psychosocial needs.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/27/14 at 11:05 AM, revealed she was the Minimum Data Set (MDS) Coordinator, who was in charge of completing the MDSs and developing the Care Plans on the South Unit until 07/03/14. She stated the care plans were generated from the computer and then reviewed to ensure interventions were appropriate which needed to be modified by software or handwritten. LPN #1 further stated the Care Plan did not have to specifically state how many staff were required to assist with ADLs or how often the assistance was needed because this was specified in the State Registered Nursing Assistant (SRNA) Care Plan Record which was a part of the permanent record.</p> <p>1. Review of Resident #14's medical record revealed the facility admitted the resident on 03/25/14, with diagnoses which included Cerebrovascular Accident (CVA), Bladder Cancer</p>	F 279	<p>Monitoring of changes to assure continuing compliance:</p> <ul style="list-style-type: none"> <li>Beginning September 11, 2014 the DON will bring all results of audits to Quality Assurance (QA) weekly x 4 and then monthly for any further recommendations and or resolutions.</li> </ul> <p>Date of compliance</p>	09-27-14	

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 127</p> <p>and Depression. Review of the Admission MDS dated 04/01/14, revealed under Section V, the Care Areas Assessment (CAA) Summary, communication and psychotropic medications had triggered for care planning. Review of the Physician's Order dated 04/01/14, revealed an order for Remeron (antidepressant medication) fifteen (15) milligrams (mg) at night for the diagnosis of Depression.</p> <p>Review of Resident #14's Comprehensive Care Plan, dated 04/14/14, revealed there was no documented evidence of care plans to address the resident's communication or psychotropic medication use.</p> <p>Interview, on 07/03/14 at 5:15 PM, with LPN #1/MDS Coordinator revealed the MDS Nurse was responsible for ensuring CAAs that triggered were addressed on the residents' care plans; however, she had not completed this resident's MDS and Care Plan. She stated the MDS Coordinator, who was responsible for completing this MDS and Care Plan, was unavailable for interview.</p> <p>Interview, on 07/03/14 at 5:30 PM, with Registered Nurse (RN) #2/Assistant Director of Nursing (ADON) revealed triggered areas on the CAA Summaries were to be addressed on the care plans by the MDS Nurses. RN #2/ADON stated the triggered areas for Resident #14 should have been care planned with interventions put in place, based on the MDS Assessment and the facility's policy.</p> <p>Interview, on 07/03/14 at 6:00 PM, with the Director of Nursing (DON) revealed it was the responsibility of the MDS Coordinators to ensure</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 128 development of the care plan from the triggered areas on the CAA Summaries.</p> <p>2. Review of Resident #16's medical record revealed the facility admitted the resident on 02/01/12 with diagnoses which included Chronic Pain Syndrome, Chronic Obstructive Pulmonary Disease (COPD), Spinal Stenosis, Depression, Rheumatoid Arthritis, Seizure Disorder, Congestive Heart Failure, and Epilepsy. Review of Resident #16's Significant Change Minimum Data Set (MDS) Assessment, dated 05/05/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status score of fifteen (15) out of fifteen (15), indicating the resident was alert and oriented. Further review revealed the facility assessed the resident as requiring extensive assist of two (2) staff for bed mobility, transfers, and toileting, and as frequently incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 05/05/14, revealed the resident had decreased physical function and was at risk for inadequate completion of daily care needs and was frequently incontinent of bowel and bladder.</p> <p>Review of Resident #16's Comprehensive Care Plan, dated 09/2013, revealed the resident was care planned for episodes of incontinence and requiring staff assist for completion of daily care due to decreased physical function related to his/her diagnoses of COPD and Spinal Stenosis. The interventions included staff assist with bathing, dressing, and grooming as needed, staff assist with transfers, and staff assist with toileting. However, the Comprehensive Care plan was not developed with individualized interventions related to how many staff was required to assist with ADLs including; toileting, incontinence care,</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 129 bed mobility and transfers.</p> <p>Review of the SRNA Care Plan dated 07/14, revealed the resident required one (1) staff for transfers, bed mobility, and toileting.</p> <p>Continued interview with LPN #1/MDS Coordinator, on 07/30/14 at 3:00 PM and review of the most recent MDS dated 05/05/14, and the SRNA Care Plan dated 07/14, revealed there was discrepancies in how many staff was required to assist with transfers, bed mobility, and toileting in comparison with the MDS and the SRNA Care Plan. She also indicated the Comprehensive Care Plan did not have specific individualized interventions, and did not specify how many staff was required to assist the resident with toileting, incontinence care, transfers, and bed mobility.</p> <p>Interview, on 07/24/14 at 1:30 PM, with Resident #16 revealed he/she "usually" went to the bathroom on his/her own as at times it had taken as long as forty-five (45) minutes for his/her call light to be answered.</p> <p>3. Review of Resident #24's medical record revealed the facility admitted the resident on 05/21/14 with diagnoses which included Chronic Dizziness, Adult Failure to Thrive, Dehydration, Hypertension and Thrombocytopenia. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/21/14 revealed the facility assessed the resident as requiring extensive assistance of one (1) person for bed mobility, transfers, ambulation, dressing, toileting and personal hygiene. Further review, revealed the facility assessed the resident as occasionally incontinent of bowel and bladder.</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 130</p> <p>Review of the Comprehensive Plan of Care, dated 06/11/14, revealed the resident had a ADL Self Care Deficit and was at risk for complications related to the deficit and required assist with transfers. The goal stated the resident would maintain ADL self performance as evidenced by no decline, would not develop complications related to decreased ADL self care performance and would participate with care and be clean, groomed and dressed. The interventions included: staff to provide only the amount of assistance/supervision to meet the resident's needs for ADLs, turn and reposition, shifting weight to enhance circulation, and staff to assist with transfers as needed. However, the Care Plan was not developed with individualized interventions related to how many staff was required to turn and reposition the resident or how often this was to be done, or how many staff was required to assist with transfers or how the resident was to be transferred.</p> <p>Further review revealed the Comprehensive Care Plan, dated 06/11/14, stated the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean and dry, and would not develop any complications associated with incontinence. There were several interventions including; maintain privacy and dignity when providing perineal care after each incontinent episode. However, the care plan was not developed with individualized interventions related to how many staff was required to toilet or assist with incontinence care, or how often the resident was to be toileted or receive incontinence care.</p> <p>Review of the SRNA Care Plan for Resident #24,</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 279	<p>Continued From page 131 dated 07/14, revealed the resident required the assistance of one for transfers, mobility and with toileting needs, and was continent of bowel and occasionally incontinent of bladder requiring the use of adult incontinence briefs.</p> <p>Further interview with LPN #1/MDS Coordinator, on 07/30/14 at 10:45 AM revealed the Comprehensive Care Plan was not developed with specific interventions related to ADLs and how much assistance was to be provided for transfers, toileting, incontinence care, and bed mobility and there was no specific interventions related to how often the toileting, incontinence care and turning and repositioning was to be done.</p> <p>Interview, on 07/25/14 at 9:30 AM, with Resident #24 revealed she had problems with call lights not being answered timely and he/she took himself/herself to the bathroom, and did not ask staff for help to do that.</p> <p>4. Review of Resident #26's medical record revealed the facility admitted the resident on 07/23/12, with diagnoses which included Depressive Disorder, Muscle Weakness, Difficulty Walking, Muscle Disuse Atrophy and Abnormality of Gait. Review of Resident #26's Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating the resident was alert and oriented. Further review revealed the facility assessed the resident as requiring extensive assist of two (2) staff for bed mobility, transfers, and toileting, and as frequently incontinent of bowel and bladder. Review of the Care Area</p>	F 279		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 132</p> <p>Assessment (CAA) dated 06/23/14, revealed the resident had decreased physical function and was at risk for inadequate completion of daily care needs and was frequently incontinent of bowel and bladder.</p> <p>Review of Resident #26's Comprehensive Care Plan dated 06/16/14, revealed the resident had an Activities of Daily Living (ADLs) self care deficit and was at risk for complications related to this deficit and required assist in transfers. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline, would not develop any complications related to decreased ADL self care performance and would participate in care and be clean, groomed and dressed through next review. There was several interventions including staff to provide only the amount of assistance/supervision needed to meet the resident's needs for all ADLs, turn and reposition shifting weight to enhance circulation, and staff to assist with transfers as needed. However, the Care Plan was not developed with individualized interventions related to how many staff were required or how often the resident was to be turned and repositioned, or how many staff was required to transfer the resident.</p> <p>Further review revealed the Comprehensive Care Plan dated 06/16/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, dry and comfortable daily, would not develop complications associated with incontinence and the resident's dignity would be maintained without embarrassment or fear through next review. There were several interventions including; maintain privacy and dignity when providing</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 133</p> <p>perineal care after each incontinence episode, and provide privacy and dignity when checking resident for incontinent episodes. However, the Care Plan was not developed with individualized interventions related to how many staff was required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting.</p> <p>Interview with LPN #1/MDS Coordinator, on 07/30/14 at 10:45 AM, and review of the most recent MDS dated 06/23/14 with the SRNA Care Plan dated 07/14 for Resident #26, revealed the following; the MDS was coded as the resident requiring extensive assist of two (2) staff for transfer, and the SRNA care plan stated one to two (1-2) for transfer; the MDS coded two (2) staff for bed mobility and the SRNA care plan stated one (1) staff to reposition every two (2) to three (3) hours; the MDS coded two (2) staff for toileting and the SRNA care plan stated one (1) assist for toileting needs and specified the resident was incontinent of bowel and bladder. LPN #1 explained the MDS coding was for the most dependent, but the SRNA Care Plan did not necessarily have to code for the most dependent because the resident may not need that much support at all times. However, she stated for this resident the SRNA Care Plan was incorrect and should have stated two (2) staff for transfers, two (2) staff for toileting, and two (2) staff for turning and repositioning.</p> <p>Interview, on 07/03/14 at 2:26 PM, with Resident #26 revealed he/she had waited for over an hour for someone to respond to his/her call light before, and had "pooped" on himself/herself during the night before as a result of having to wait for staff's assistance. Resident #26 stated</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 134</p> <p>SRNA #19 had been assigned to his/her care the night before when he/she had "pooped" on himself/herself, and did not change him/her after he/she asked the SRNA to be changed. Resident #26 stated no one changed him/her until day shift reported to work that morning. During the interview, Resident #26 started crying and stated he/she felt like he/she "wasn't supposed to be clean". The resident stated he/she felt staff "did not want to change" him/her.</p> <p>Interview, on 07/03/14 at 2:51 PM, with SRNA #20 revealed she had come in early that morning to escort Resident #26 to a doctor's appointment. SRNA #20 stated when she arrived she observed Resident #26 to be soiled and had a lot of bowel movement on him/her. SRNA #20 stated this was not normal for this resident who was able to request assistance when he/she needed to be changed.</p> <p>Interview, on 07/03/14 at 7:00 PM, with Registered Nurse (RN) #6 revealed the night before, she worked with SRNA #19 and SRNA #21. She stated the two (2) SRNAs did not work as a team that night, due to personal conflict. RN #6 stated she assisted SRNA #19 with changing, turning, and positioning the residents at 1:30 AM and 3:00 AM, that were care planned for requiring two (2) staff for assistance. She further stated she could not assist SRNA #19 with residents on the last round at 5:00 PM, as she had to complete her medication pass. RN #6 revealed SRNA #21 had a SRNA orientee working with her, who assisted her until the end of the shift. She reported Resident #26 asked to be changed about 5:30 AM, and she told SRNA #19 to change the resident as he/she was receiving intravenous (IV) fluids at seventy-five (75) milliliters (mls) per</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 135</p> <p>hour which caused him/her to urinate frequently. Continued interview with RN #6 revealed SRNA #19 told her (RN #6) she was working on getting the residents up and ready for breakfast. RN #6 explained the night shift staff was responsible for getting certain residents up and ready for breakfast. RN #6 stated the conflict between SRNA #19 and SRNA #21 impacted the residents' care that night. She stated she should have told SRNA #19 that getting the residents up out of bed was not as important as tending to residents who were asking for care since she was her supervisor. Per interview, RN #6 revealed she knew Resident #26 needed to be changed on the last rounds; however, she had not ensured this was done. She revealed it would be "terrible" not to be changed when wet or soiled with stool, and the facility provided training on neglect as a form of abuse. However, she reported she had not taken her concern to Administration, but should have.</p> <p>Interview, on 07/23/14 at 9:08 AM, with SRNA #19 revealed she did not feel comfortable providing incontinence care for Resident #26 by herself because the resident's legs were stiff and he/she would slide when standing up and holding on to the transfer pole from the recliner chair in which she slept at night. She stated she changed the resident the last time on the morning of 07/03/14 at 4:30 AM or 5:30 AM, and the resident rang the call light at 6:30 AM wanting to be changed again. She further stated she was unable to find anyone to assist with providing incontinence care to Resident #26 during the last rounds because RN #6 was busy and SRNA #21 had ignored her when she requested assistance. Further interview revealed she did not return to Resident #26's room prior to leaving for the shift;</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	Continued From page 136 however she told SRNA #9 and SRNA #6 who had come on shift, the resident needed changed.  5. Review of Resident #30's medical record revealed diagnoses which included Dementia, Paranoia, Osteoporosis, and Arthritis. Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/05/14, revealed the facility assessed the resident as having a BIMS of five (5) indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons with bed mobility, transfers, and toileting, and as frequently incontinent of urine and occasionally incontinent of bowel. Review of the CAA, dated 05/05/14, revealed the resident had decreased cognitive and physical function.  Review of the Comprehensive Plan of Care, dated 06/10/14, revealed the resident had a ADL Self Care Deficit and was at risk for complications related to the deficit and required assist with transfers. The goal stated the resident would maintain ADL self performance as evidenced by no decline, would not develop complications related to decreased ADL self care performance and would participate with care and be clean, groomed and dressed. The interventions included: staff to provide only the amount of assistance/supervision to meet the resident's needs for ADLs, turn and reposition, shifting weight to enhance circulation, and staff to assist with transfers as needed. However, the Care Plan was not developed with individualized interventions related to how many staff was required to turn and reposition the resident or how often this was to be done, or how many staff was required to assist with transfers or how the resident was to be transferred.	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	Continued From page 137  Further review revealed the Comprehensive Care Plan, dated 06/10/14, stated the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean and dry, and would not develop any complications associated with incontinence. There were several interventions including: maintain privacy and dignity when providing perineal care after each incontinent episode. However, the care plan was not developed with individualized interventions related to how many staff was required to toilet or assist with incontinence care, or how often the resident was to be toileted or receive incontinence care.  Review of the SRNA Care Plan, dated 07/14, revealed the resident required the assistance of one (1) staff for transfers, mobility, and turning and repositioning, and required the assistance of one (1) staff for toileting in the bathroom every two (2) to three (3) hours while awake and prn (as needed).  Continued interview with LPN #1/MDS Coordinator, on 07/30/14 at 1:40 PM and review of the MDS and SRNA Care Plan revealed there were discrepancies in how many staff were needed to assist the resident with ADL's including transfers, bed mobility, and toileting in comparing the MDS and SRNA Care Plan. Further interview revealed the Comprehensive Care Plan was not developed with specific interventions related to ADLs and how much assistance was to be provided for transfers, toileting, incontinence care, and bed mobility and there was no specific interventions related to how often the toileting, incontinence care and turning and repositioning	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3678 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 138 was to be done.</p> <p>6. Review of Resident #31's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Debility, and Mood Disorder. Review of the Annual MDS Assessment, dated 07/06/14, revealed the facility assessed the resident as having a BIMS of fourteen (14) out of fifteen (15), indicating the resident was alert and oriented. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for bed mobility, transfers, and toilet use, and as frequently incontinent of urine and always incontinent of bowel. Review of the Care Area Assessment (CAA) dated 12/20/13, revealed the resident required assistance with transfers due to significant generalized weakness and self reports incontinence of bowel.</p> <p>Review of the Comprehensive Plan of Care, dated 07/06/14, revealed the resident had a ADL Self Care Deficit and was at risk for complications related to the deficit and required assist with transfers. The goal stated the resident would maintain ADL self performance as evidenced by no decline, would not develop complications related to decreased ADL self care performance and would participate with care and be clean, groomed and dressed. The interventions included: staff to provide only the amount of assistance/supervision to meet the resident needs for ADLs, turn and reposition, shifting weight to enhance circulation, staff to assist with transfers as needed, and two (2) person lift required for transfers. However, the Care Plan was not developed with individualized interventions related to how many staff was required to turn and reposition the resident or</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 139 how often this was to be done.</p> <p>Further review revealed the Comprehensive Care Plan, dated 07/06/14, stated the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean and dry, and would not develop any complications associated with incontinence. There were several interventions including: maintain privacy and dignity when providing perineal care after each incontinent episode. However, the care plan was not developed with individualized interventions related to how many staff was required to toilet or assist with incontinence care, or how often the resident was to be toileted or receive incontinence care.</p> <p>Review of the SRNA Care Plan, revealed the resident required the assistance of one (1) with mobility, two (2) for transfers, and two (2) for turning and repositioning. Further review revealed the resident required the assist of one (1) or two (2) for toileting needs, was to be checked and changed every two (2) to three (3) hours and was to be encouraged to use the toilet.</p> <p>Further interview with LPN #1/MDS Coordinator, on 07/30/14 at 1:40 PM and review of the most recent MDS dated 07/06/14 in comparison with the SRNA Care Plan dated 07/14, revealed there were discrepancies in how many staff was required to assist with toileting and bed mobility. She also indicated the Comprehensive Care Plan did not have specific individualized interventions, and did not specify how many staff was required to assist the resident with toileting, incontinence care, and bed mobility.</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 279	<p>Continued From page 140</p> <p>Continued interview with LPN #1/MDS Coordinator, on 07/27/14 at 11:05 AM, and 07/30/14 at 10:45 AM and 4:30 PM revealed through the winter she had completed all MDSs in the building and this went on for several months, and since that point her job was to do the MDS on South Unit as well as develop the Care Plans for the South Unit. She stated she had no formal training related to developing care plans but gathered information to write the care plan from the MDS, the ADL Reports which showed the amount of assistance the resident required for ADLs the past seven (7) days prior to the MDS, looked at Physician's Orders, reviewed the clinical record, and talked to staff. She stated the Comprehensive Care Plans did not need to be developed with individualized interventions related to how much ADL support was to be provided (how many staff was needed to provide the care) on the comprehensive care plan because staff could refer to the SRNA Care Plan for this information. She further stated staff would not know how to care for the residents just by looking at the Comprehensive Care Plan related to the resident's ADLs. Continued interview revealed she was revising the SRNA Care Plan until 02/01/14, and then it was the ADON's responsibility to ensure they were revised with any changes needed and also reviewed monthly. However, she stated she did not communicate changes to the ADON when completing MDS Assessments.</p> <p>Interview with RN #4/ADON on South Unit, on 07/31/14 at 8:26 AM, revealed she took the SRNA Care Plans to the morning meetings along with a copy of the previous days Physician's Orders and updated the Master Copy of the SRNA Care Plan during the meeting. She stated</p>	F 279		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 141</p> <p>she then went to the unit and updated the SRNA Care Plan in the SRNA Book at the desk and on the back of the resident's door. She further stated for new admissions, she would review any information from the hospital for any Physician information, Physician's Orders, Discharge Summaries from hospitals or Home Health Summaries and also would use the admission assessments such as the skin risk, fall risk assessments to complete the SRNA Care Plan. Further interview revealed she did not use the MDS to get information for the SRNA Care Plan, and also did not review the Comprehensive Care Plan when reviewing or updating the SRNA Care Plans. She stated, she had reviewed the Comprehensive Care Plans this week and felt they should be more specific as far as functional status to show how many staff were required to turn and reposition, to transfer, and to toilet and provide incontinence care. RN #4/ADON, stated it was her understanding that the MDS was a picture of the resident's health and the MDS information should be used to develop the Comprehensive Care Plan. Continued interview revealed, she felt the Comprehensive Care Plans should match the SRNA Care Plans. She stated she had never compared the MDS, the Comprehensive Care Plans and the SRNA Care Plans until this was brought up during survey.</p> <p>Interview with the Director of Nursing (DON), on 08/01/14 at 9:00 AM, revealed, "The care plan should mirror the individual." She stated it would be important to make sure the care plans were developed according to MDS guidelines. She further indicated the Comprehensive Care Plans should be individualized to meet the residents' needs and staff should be able to take care of the resident by looking at the Comprehensive Care</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 279	<p>Continued From page 142</p> <p>Plan. Further interview revealed the Comprehensive Care Plans should be specific as to how many staff was required for transfers, toileting, ADLs, incontinence care, bed mobility and should also match the SRNA Care Plan in order for staff to provide the correct care for the residents. She stated during survey, she realized the Comprehensive Care Plans were not individualized with specific interventions related to ADLs and did not match the SRNA Care Plans. She also stated, that during the survey she realized the SRNA Care Plans were not correct and did not match the MDSs in how much assistance the resident required. Continued interview revealed the SRNA Care Plans should match the Comprehensive Care Plan. However, she stated the MDS did not always have to match the Comprehensive Care Plan because a person may require more assistance at one time of the day than another time, and this would need to be explained on the Comprehensive Care Plan. The DON stated the Interdisciplinary (IDT) Comprehensive Care Plan should be developed in collaboration with the MDS Coordinators, the nurses, the ADONs and the SRNAs. However, she stated due to turn over in MDS Coordinators and ADONs this was not always done.</p> <p>Interview with the former Administrator, on 07/31/14 at 10:14 AM, who was the Administrator from 05/15/14 until 07/11/14 revealed the facility had noted the care plans were not accurate prior to the survey and they had discussed this in the morning meetings. She stated they put together a team to look at MDSs due to an internal audit showing a concern and the ADONs were reviewing the care plans for completeness. However, she stated she did not know if the care plans were specific related to functional status</p>	F 279			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 279	Continued From page 143 because she did not review them.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Resident Assessment Instrument (RAI) Manual 3.0 Version, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was reviewed and revised for twelve (12) of thirty-seven (37) sampled residents (Residents #5, #8, #11, #17, #24, #27, #28, #29, #32, #33, #36 and #37).	F 280	F 280  Immediate corrective action for residents found to be affected:  ♦ Comprehensive care plans have been reviewed and revised by SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD or licensed nurse on July 23 – September 02, 2014 for residents #27, #29, #5, #28, #8, #36, #33, #17, #32, #11, #24, #37.  Identification of other residents with the potential to be affected:  ♦ 100% audit of resident current medical record has been completed on July 29, 2014 to ensure that the comprehensive care plans to include measureable objectives and time tables to meet residents' medical and nursing mental and psychosocial needs identified in the comprehensive assessment have been completed by the IDT that includes the DON, ADON, Licensed Nurses, MDSN, CRS and SCC. With comprehensive care plans updated accordingly July 29 to September 125, 2014.	

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 280	<p>Continued From page 144</p> <p>Review of the Comprehensive Plans of Care for Residents #5, #8, #27, #28, #29, #36, #33, #17, #32, and #37 revealed the Care Plans were not revised to include specific interventions related to how many staff were required and/or how often the residents were to be toileted, receive incontinence care, be turned and repositioned, and/or be transferred in order for staff to provide the care indicated as required on the Quarterly Comprehensive Assessment.</p> <p>In addition, the facility failed to ensure the Comprehensive Care Plan was revised for Resident #11 when the resident was diagnosed with a Urinary Tract Infection (UTI) on 11/21/13. Also, the facility failed to ensure the Comprehensive Care Plan was revised for Resident #24 related to Physician's Orders for TED Hose for bilateral leg edema.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans-Comprehensive", revised 10/10, revealed Assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition changed. The Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when there was a significant change in the resident's condition, when the desired outcome was not met, when the resident was re-admitted to the facility from a hospital stay, and at least quarterly.</p> <p>Review of the facility's policy titled, "Interdisciplinary Team Care Assessments", dated 12/10, revealed each resident of the facility would have a plan of care. Continued review of the</p>	F 280	<p>Measures taken to assure there will not be a recurrence:</p> <ul style="list-style-type: none"> <li>◆ Education has been completed for the MDSN, ADON, SSD, QoLD, and DSM, related to policies and procedures for comprehensive care plans completed by the CRS on August 14, 2014.</li> <li>◆ Beginning September 22, 2014, the DON, ADON, SDC, WCN or MDSN will audit weekly the CAA completion and comprehensive care plans that have been completed for that <i>the previous</i> week x 4 weeks to validate completion and accuracy. <i>This will include observation and interviews with residents with BIMS 8 and above.</i></li> <li>◆ After the 4 weeks of review the DON, ADON, SDC, WCN or MDSN will then audit 10% sample of CAAs and comprehensive care plans to monitor for completeness and accuracy monthly. This will continue until instructed otherwise by the QA Committee.</li> <li>◆ Beginning September 8, 2014 the DON, ADON, SDC, WCN or MDSN will review care plans as necessary at the daily (M-F) clinical meeting to initiate, review and/or revise care plans as needed for change of conditions.</li> </ul>	

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 145</p> <p>policy revealed changes in a resident's condition often required changes to be made to the care plan either by change in individual approaches or by the addition of new problems to the care plan. Further review revealed when changes in a resident's condition, medications, treatments or approaches occurred staff was to update the care plan immediately by hand and written on the hard copy until it could be updated in the computer. Review revealed once the care plan had been updated in the computer, a copy was to be printed and placed in the resident's medical record.</p> <p>Review of the "Resident Assessment Instrument Version 3.0 Manual", (section 4.1) revealed the results of the assessment which must accurately reflect the resident's status and needs, are to be used to review and revise each resident's Comprehensive Plan of Care. Section 4.7 revealed the Care Plan must be reviewed and revised periodically and services provided or arranged must be consistent with each resident's written plan of care.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 07/27/14 at 11:05 AM, revealed she was the Minimum Data Set (MDS) Coordinator, who was in charge of completing the MDSs and developing the Care Plans on the South Unit until 07/03/14. However, she stated since February 2014 she was no longer responsible for revising the Care plans with the Quarterly Assessments. She stated the Director of Nursing (DON) and the two (2) Assistant Directors of Nursing (ADONS) as well, as other members from the clinical meeting were updating the Care Plans for the Quarterly Assessments. She further stated the floor nurses were responsible for updating the Care Plans</p>	F 280	<p>Monitoring of changes to assure continuing compliance:</p> <ul style="list-style-type: none"> <li>Beginning September 11, 2014 the DON will bring all results of audits to QA weekly x 4 and then monthly for any further recommendations and or resolutions.</li> </ul> <p>Date of compliance <b>09-27-14</b></p>		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 280	<p>Continued From page 146</p> <p>daily with Physician's Orders and changes in the resident's condition. Continued interview with LPN #1 revealed the Care Plan did not need revisions with the Quarterly Assessment to indicate how many staff were required to assist with ADLs such as transfers, bed mobility, toileting, and incontinence care or how often the assistance was needed because this was specified on the State Registered Nursing Assistant (SRNA) Care Plan Record which was a part of the permanent record and updated at least monthly by the ADONs.</p> <p>Interview on 07/31/14 at 8:26 AM, with Registered Nurse (RN) #4/ADON on the South Unit, revealed the MDS Coordinators were responsible for updating the Care Plans for MDSs including Significant Change, Annuals, Admissions, and Quarterlies and she was responsible for updating the SRNA Care Plans as well.</p> <p>Interview with the DON, on 08/01/14 at 9:00 AM, revealed the MDS Nurse was responsible for updating the Care Plans for the Quarterly Assessments and the ADONs, MDS Nurse, the floor nurses, and the SRNAs should work together to ensure the Care Plans were accurate. She further stated, the nurses on the floor could update the care plans daily with changes in resident's condition or Physician's Orders.</p> <p>1. Review of Resident #5's medical record revealed the facility re-admitted the resident on 04/10/14, with diagnoses which included Muscle Weakness, Osteoporosis, Sepsis and Arthritis. Review of Resident #5's Quarterly MDS Assessment, dated 05/15/14, revealed the facility assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status</p>	F 280		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 147</p> <p>(BIMS) score of four (4). Further review of the MDS revealed the facility assessed the resident as requiring extensive physical assistance of two (2) staff with his/her ADLs including bed mobility, transfers, and toileting and as always incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 04/17/14, revealed the resident required assistance with toileting, had episodes of incontinence, and staff would provide incontinence care as indicated. Further review revealed staff was to assist with transfers and mobility.</p> <p>Review of Resident #5's Comprehensive Care Plan, dated 02/06/14 revealed the resident had an Activities of Daily Living (ADLs) self care deficit and was at risk for complications related to the deficit and required assistance with transfers. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline in stated level, would not develop any complications related to decreased ADL self care performance, and would participate with care and be clean, groomed and dressed. There were several interventions including; staff to provide only the amount of assistance/supervision needed to meet the resident's needs with ADLs, turn and reposition to enhance circulation, and staff to assist with two (2) person lift during transfers. However, the Care Plan was not revised to indicate individualized Interventions related to how many staff were required or how often the resident was to be turned and repositioned.</p> <p>Further review revealed the Comprehensive Care Plan dated 02/16/14, revealed the resident required extensive assistance with bed mobility with a goal the resident would have intact skin.</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 148</p> <p>The interventions included assist prn (as needed) to reposition/shift weight to relieve pressure. However, the Care Plan was not revised to indicate individualized interventions related to how many staff were required for bed mobility or how often the resident was to be repositioned.</p> <p>Continued review revealed the Comprehensive Care Plan dated 02/16/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, and dry, would not develop any complications associated with incontinence and dignity would be maintained without embarrassment or fear. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not revised to indicate individualized interventions related to how many staff were required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting.</p> <p>In reviewing the most recent MDS dated 05/15/14, with the SRNA Care Plan dated July 2014, for Resident #5 with LPN #1, the following was noted; the MDS was coded for extensive assist of two (2) staff for transfer, and the SRNA Care Plan stated assist of one (1) to two (2) staff for transfers; the MDS was coded for extensive assist of two (2) staff for bed mobility, and the SRNA Care Plan stated one (1) to two (2) staff to reposition every two (2) to three (3) hours; the MDS was coded for extensive assistance of two (2) for toileting and the SRNA Care Plan stated assist of one (1) to two (2) to toilet and check and change every two (2) to three (3) hours and as needed. LPN #1 stated there were discrepancies</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 149</p> <p>in ADL support needed with the MDS and the SRNA Care Plan. Further interview revealed the Comprehensive Care Plan was not revised with individualized interventions to indicate how many staff was required for bed mobility or how often the resident was to be repositioned. She further indicated the Comprehensive Care Plan was not revised to indicate how many staff was required for incontinence care and toileting, or how often the resident was to receive incontinence care and toileting.</p> <p>Interview, on 07/23/14 at 9:08 AM with SRNA #19, revealed there were usually two (2) aides on the night shift on the South Unit where Resident #5 resided, and if a resident required two (2) to assist she would get the nurse to help rather than work with SRNA #21 due to a conflict with her. She stated she could get the nurses to help her until last rounds which usually started about 6:00 AM, and sometimes the nurses could assist her with last rounds as well. Continued interview revealed there were seven (7) residents on her side of the South Unit who required two (2) staff to assist with incontinence care. She further stated maybe one (1) or two (2) times a month she would be unable to find someone to assist her with last rounds for these residents because some nurses would not make SRNA #21 assist her. SRNA #19 stated Resident #5 walked to the bathroom with assistance and she took the resident to the bathroom about 5:30 AM on the morning of 07/03/14 and the resident was not wet when she left.</p> <p>Interview with SRNA #9 on 07/23/14 at 1:52 PM, revealed on the morning of 07/03/14 when she arrived on the unit she found Resident #5 in the bed and the resident as well as the bed linens</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 150</p> <p>were soaking wet. She stated every time she followed SRNA #19 when she worked with SRNA #21, she found residents soaking wet with urine.</p> <p>2. Record review revealed the facility admitted Resident #8 on 10/16/12, with diagnoses which included Non Small Cell Lung Cancer, Status post lysis of adhesions and wedge resection, resection of the sixth and seventh ribs and Gore Tex Reconstruction of the chest, and Liver one (1) centimeter nodule. Review of Resident #8's Quarterly Minimum Data Set (MDS) Assessment, dated 03/20/14, revealed the facility assessed the resident as requiring one (1) person assist for bed mobility, transfer, and toilet use.</p> <p>Review of the Comprehensive Care Plan, dated 06/17/14, revealed Resident #36 was care planned for ADL self care deficit. The goal stated the resident would maintain ADL self performance levels, the resident would not develop complications related to decreased ADL self performance, and the resident would participate with care. The interventions included: staff to provide only the amount of assistance/supervision to meet the residents needs, and staff to assist with transfers as needed, and turn and reposition shifting weight. However, the Comprehensive Care plan was not revised with individualized interventions related to the specific information on the required number of staff assist needed for transfers and bed mobility, and how often the resident was to be turned and repositioned.</p> <p>Further review of the Comprehensive Care Plan dated October 2013, revealed the resident required assist with ADLs due to decreased physical function. The goal stated the resident</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 280	<p>Continued From page 151</p> <p>would have needs met via staff assist. The interventions included assisting with daily care as needed, and assist with toileting needs at least every two (2) to three (3) hours. However, the Care Plan was not revised to include individualized interventions related to how many staff were required to assist with toileting.</p> <p>Review of the SRNA Care Plan, dated July 2014 revealed the resident required the assist of one (1) staff for transfers, toileting, and bed mobility.</p> <p>Interview with LPN #1, on 07/30/14 at 3:20 PM, revealed the Comprehensive Plan of Care was not revised with individualized interventions related to the required number of staff needed to assist with toileting and incontinence care, transfers, and bed mobility. In addition, the Care Plan was not specific as to how often the resident was to be turned and repositioned.</p> <p>3. Review of Resident #17's medical record revealed the facility admitted the resident on 09/10/13, with diagnoses which included Paraplegia, Depressive Disorder, Anxiety and Muscle Weakness. Review of the Quarterly MDS Assessment dated 06/23/14, revealed the facility assessed Resident #17 as requiring the extensive assist of two (2) staff for bed mobility, transfers, and toilet use.</p> <p>Review of the Comprehensive Care Plan dated 04/08/13, revealed the resident had an ADL self care deficit as evidenced by need for assistance with ADLs related to Non-Hodgkin Lymphoma, Paraplegia and Depression. The goals stated the resident would not develop any complications related to decreased ADL self performance, would maintain ADL self performance levels, and</p>	F 280		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 152</p> <p>would participate with care and be clean, groomed, and dressed. The interventions included; provide only the amount of assist/supervision to meet needs for all ADLs, assist with ADLs as needed, turn and reposition, shifting weight to enhance circulation, and staff assist with sliding board. However, the Care Plan was not revised with individualized interventions related to how many staff was required to assist with transfers with the sliding board, and how many staff was required to assist with turning and repositioning or how often the resident was to be turned and repositioned.</p> <p>Further review of the Comprehensive Care Plan dated October 2013 revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goal stated the resident would not develop any complications associated with incontinence. The interventions included; maintain privacy and dignity when checking for incontinent episodes. However, the Care Plan was not revised to include individualized interventions regarding how the resident was to be toileted, how often the resident was to be toileted or how many staff was required to assist with toileting.</p> <p>Review of the SRNA Care Plan dated July 2014, revealed the resident required the assist of one (1) staff with the sliding board, required the assist of two (2) staff for turning and repositioning every two (2) to three (3) hours. Further review revealed the resident required the assist of two (2) for toileting, wore adult briefs and was to be toileted every two (2) to three (3) hours while awake and as needed.</p> <p>Interview with LPN #1, on 07/30/14 at 2:15 PM,</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 280	<p>Continued From page 153</p> <p>and review of the MDS dated 06/23/14; and, the SRNA Care Plan dated July 2014 revealed the Comprehensive Care Plan was not revised with individualized interventions related to how many staff was required to transfer the resident with the sliding board, how many staff was required to assist the resident with bed mobility, or how often the resident was to be turned and repositioned. Further interview revealed the Care Plan was not revised to include individualized interventions regarding how the resident was to be toileted, how often the resident was to be toileted or how many staff was required to assist with toileting.</p> <p>4. Review of Resident #27's medical record revealed the facility admitted the resident on 06/14/13, with diagnoses which included Anxiety, Senile Dementia, Muscle Weakness, Difficulty Walking and Fracture of the Femur. Review of the Quarterly MDS Assessment, dated 05/21/14, revealed the facility assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status of three (3) indicating severe cognitive impairment. Further review of the MDS revealed the facility assessed the resident to require extensive physical assistance of two (2) staff with his/her ADLs including bed mobility, transfers, and toileting and as being frequently incontinent of bowel and bladder. Review of the Care Areas Assessment (CAA) dated 02/18/14, revealed the resident had frequent urinary incontinence and required assist with toileting as needed and perineal care after each incontinent episode, and was to be assisted with bed mobility as needed.</p> <p>Review of Resident #27's Comprehensive Care Plan dated 05/28/14, revealed the resident had an Activities of Daily Living (ADL's) self care</p>	F 280		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 154</p> <p>deficit and was at risk for complications related to the deficit and required assistance with transfers. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline in stated level, would not develop any complications related to decreased ADL self care performance, and would participate with care and be clean, groomed and dressed. There were several interventions including; staff was to provide only the amount of assistance/supervision needed to meet the resident's needs with ADLs, turn and reposition to enhance circulation, and a two (2) person lift required during transfers. However, the Care Plan was not revised with individualized interventions related to how many staff were required to turn and reposition the resident or how often the resident was to be turned and repositioned.</p> <p>Continued review revealed the Comprehensive Care Plan dated 05/28/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, and dry, would not develop any complications associated with incontinence and dignity would be maintained without embarrassment or fear. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not revised with individualized interventions related to how many staff were required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting.</p> <p>Review of the most recent MDS dated 06/27/14, with the SRNA Care Plan dated 07/14 for Resident #27 with LPN #1 on 07/30/14 at 10:45</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 155</p> <p>AM, the following was noted; the MDS was coded for extensive assist of two (2) for transfers, and the SRNA Care Plan stated assist of one (1) for transfers, the MDS coded extensive assist of two (2) for bed mobility, and the SRNA Care Plan stated one (1) staff was required to reposition every two (2) to three (3) hours and as needed, the MDS coded for extensive assist of two (2) for toileting and the SRNA Care Plan stated assist of one (1) to take to the bathroom before meals, at night and as needed. LPN #1 acknowledged there were discrepancies in the level of ADL support needed on the MDS in comparison with the SRNA Care Plan. LPN #1 further acknowledged the Comprehensive Care Plan was not revised, with individualized interventions, to indicate how many staff was required or how often the resident was to be turned and repositioned, how often the resident was to be toileted, and how many staff was required to assist the resident to the toilet.</p> <p>Interview, on 07/23/14 at 9:08 AM with SRNA #19 revealed she had performed incontinence care on Resident #27 during last rounds on the morning of 07/03/14 because he/she did not require two (2) to assist with incontinence care.</p> <p>Interview, on 07/23/14 at 1:52 PM, with SRNA #9 revealed on the morning of 07/03/14 she found Resident #27 about 7:00 AM wet with a brown ring on the sheets around the resident which indicated the resident had not received incontinence care for many hours.</p> <p>5. Review of Resident #28's medical record revealed the facility admitted the resident on 03/06/13, with diagnoses which included Difficulty in Walking, Muscle Weakness, Renal Failure,</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 156</p> <p>Chronic Kidney Disease and Failure to Thrive. Review of the Quarterly MDS, dated 03/26/14, revealed the facility assessed the resident to be cognitively impaired with a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicating the resident was cognitively impaired. Further review of the MDS revealed the facility assessed the resident to require extensive physical assistance of two (2) staff for most of his/her ADLs including bed mobility and transfers, and extensive assistance of one (1) staff for toileting and as frequently incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 12/24/13, revealed the resident used the bathroom for toileting needs.</p> <p>Review of Resident #28's Comprehensive Care Plan dated 06/03/14, revealed the resident had Activities of Daily Living (ADL's) self care deficit and was at risk for complications related to the deficit. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline in stated level, would not develop any complications related to decreased ADL self care performance, and would participate with care and be clean, groomed and dressed. There were several interventions including staff was to provide only the amount of assistance/supervision needed to meet the resident's needs with ADLs, and turn and reposition to enhance circulation. However, the Care Plan was not revised with individualized interventions to indicate how many staff were required to turn and reposition the resident or how often the resident was to be turned and repositioned, and how many staff was required for transfers.</p> <p>Continued review revealed the Comprehensive</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 157</p> <p>Care Plan dated 06/03/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, and dry, and would not develop any complications associated with incontinence. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not revised with individualized interventions related to how many staff was required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting.</p> <p>In reviewing the most recent MDS dated 03/26/14, with the SRNA Care Plan dated July 2014 for Resident #28 with LPN #1, on 07/30/14 at 10:45 AM, the following was noted; the MDS was coded for extensive assist of two (2) for transfer, and the SRNA Care Plan stated assist of one (1) to transfer; the MDS was coded for extensive assist of two (2) for bed mobility and the SRNA Care Plan stated the resident was to be turned and repositioned every two (2) to three (3) hours with the assist of one (1). LPN #1 acknowledged there were differences in the ADL support needed for transfers, and bed mobility with the MDS and SRNA Care Plan. She further indicated the Comprehensive Care Plan was not revised as to how often to turn and reposition the resident or how much assistance was needed, or how the resident was to be transferred and how much assistance was needed. She further stated the Comprehensive Care Plan was not revised to specify if the resident was to be checked and changed, assisted to the toilet, or how often the resident required incontinence care and toileting.</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 158</p> <p>Interview on 07/23/14 at 9:08 AM with SRNA #19, revealed she had performed incontinence care for Resident #28 on the last rounds the morning of 07/03/14. However, interview with SRNA #9 on 07/23/14 at 1:52 PM, revealed shortly after 7:00 AM, she found Resident #28 with an extremely "soaked brief".</p> <p>6. Review of Resident #29's medical record revealed the facility admitted the resident on 09/28/12, with diagnoses which included Muscle Weakness, Alzheimer's Disease, Abnormality of Gait, and history of Urinary Tract Infection (UTI). Review of the Quarterly MDS Assessment, dated 07/07/14, revealed the facility assessed the resident to be severely cognitively impaired. Further review of the MDS revealed the facility assessed Resident #29 to require extensive physical assistance of two (2) staff with his/her ADLs including bed mobility, transfers, toilet use and as always incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 03/25/14, revealed the resident had decreased physical and cognitive impairment.</p> <p>Review of Resident #29's Comprehensive Care Plan dated 06/01/14 revealed the resident had an Activities of Daily Living (ADL's) self care deficit and was at risk for complications related to the deficit requiring assistance with transfers. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline in stated level, would not develop any complications related to decreased ADL self care performance, and would participate with care and be clean, groomed and dressed. There were several interventions including; staff to provide only the amount of assistance/supervision needed to meet the resident's needs with ADLs, turn and</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 159</p> <p>reposition to enhance circulation and a two (2) person lift required during transfers. However, the Care Plan was not revised with individualized interventions to indicate how many staff were required to turn and reposition the resident or how often the resident was to be turned and repositioned.</p> <p>Continued review revealed the Comprehensive Care Plan dated 06/01/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, and dry, and would not develop any complications associated with incontinence, and the resident's dignity would be maintained without embarrassment or fear. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not individualized with individualized interventions to indicate how many staff was required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting.</p> <p>In reviewing the most recent MDS dated 07/07/14, with the SRNA Care Plan dated 07/14 for Resident #29 with LPN #1, on 07/30/14 at 10:45 AM, the following was noted; the MDS coded extensive assistance of two (2) for bed mobility, and the SRNA Care Plan stated assist of one (1) to two (2) to reposition every two (2) to three (3) hours. LPN #1 indicated there was discrepancies in the level of ADL support required for the MDS and SRNA Care Plan related to bed mobility. Further interview with LPN #1 revealed the Comprehensive Care Plan was not revised related to how many staff was required to turn</p>	F 280		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 160</p> <p>and reposition the resident or how often the resident was to be turned, how many staff was required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting.</p> <p>Interview on 07/03/14 at 5:53 PM with LPN #8 revealed she observed Resident #29 to be "beyond soaked" the morning of 07/03/14 and indicated the resident appeared to not have been changed throughout the night. Interview on 07/23/14 at 9:08 AM with SRNA #19, revealed on the morning of 07/03/14 for the last round of the night shift, she did not perform incontinence care for Resident #29. She stated the resident should have received incontinence care at 5:00 AM; however, she was unable to find anyone to assist her with Resident #29 who required the assistance of two (2) staff for incontinence care. She explained this was because RN #6 was busy administering medications and due to a conflict with SRNA #21 who would not work with her.</p> <p>Interview, on 07/03/14 at 7:00 PM, with RN #6 revealed the night before, she worked with SRNA #19 and SRNA #21. She stated the two (2) SRNAs did not work as a team that night, due to personal conflict. RN #6 stated she assisted SRNA #19 with changing, turning, and positioning the residents at 1:30 AM and 3:00 AM; she stated they were care planned for requiring two (2) staff for assistance. She stated she could not assist SRNA #19 with residents on the last round at 5:00 PM, as she had to complete her medication pass. RN #6 stated the conflict between SRNA #19 and SRNA #21 impacted the residents' care that night.</p> <p>7. Review of Resident #32's medical record</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 161</p> <p>revealed the facility admitted the resident on 05/24/13, with diagnoses which included a History of Falls, Stroke with Right Hemiplegia (Paralysis of one side of the body), Mental Disorder and Seizure Disorder. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14) which indicated no cognitive impairment. Continued review of the MDS Assessment revealed the facility assessed Resident #32 to require extensive assistance of two (2) staff for bed mobility, transfers, and toilet use.</p> <p>Review of the Comprehensive Care Plan dated June 2014, revealed the resident had a ADL self care deficit as evidenced by assistance required with ADLs related to a history of a Cerebral Vascular Accident (CVA) with Right Hemiparesis. The goal stated the resident would not develop complications related to decreased ADL self care performance. There were several interventions including provide only the amount of assistance needed to meet needs for all ADLs, turn and reposition prn (as needed), shifting weight to enhance circulation, and assist with transfers as needed. However, the Care Plan was not revised with individualized interventions related to how many staff was required to assist with turning and repositioning and transfers. In addition, the Care Plan was not revised to state how often the resident was to be turned and repositioned.</p> <p>Further review of the Comprehensive Care Plan, dated June 2014, revealed the resident had the potential for complications associated with incontinence of bowel and bladder. The goal stated the resident would not develop complications with incontinence. There were</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 162</p> <p>several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not revised with individualized interventions related to how many staff was required to assist with toileting and incontinence care. In addition, the Care Plan was not revised to state how often the resident was to be toileted or receive incontinence care.</p> <p>Review of the SRNA Care Plan dated July 2014, revealed the resident required a stand up lift for transfers using two (2) staff, was to be turned and repositioned every two (2) to three (3) hours with the assist of two (2) staff, and required the assist of two (2) staff for toileting, wore adult briefs and was to be toileted every two (2) to three (3) hours while awake and as needed.</p> <p>Interview and review of the Comprehensive Care Plan with LPN #1, on 07/30/14 at 1:40 PM revealed Resident #32's Care Plan was not revised with specific interventions related to how many staff was required to assist with turning and repositioning and transfers, how often the resident was to be turned and repositioned, or how often the resident was to be toileted and receive incontinence care.</p> <p>8. Review of Resident #33's medical record revealed diagnoses which included Anemia, Hypertension, Hyperlipidemia, Non Alzheimer's Dementia, and Parkinson's Disease. Review of the Quarterly MDS Assessment dated 05/15/14, revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for bed mobility, transfers, and toilet use.</p> <p>Review of the Comprehensive Plan of Care,</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 163 dated 05/19/14 revealed the resident had the potential for complications associated with incontinence of bowel/bladder. The goal stated the resident would be kept clean, dry and comfortable, and the resident would not develop any complications associated with incontinence. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the care plan was not revised with individual interventions related to how often the resident was to be toileted or receive incontinence care or how many staff was required to assist.</p> <p>Further review of the Comprehensive Plan of Care, dated December 2013, revealed the resident needed assist with ADLs due to decreased physical and cognitive function. The goal stated the resident would have needs met via staff assist. There were several interventions including assist with daily care needs. The Care Plan was not revised to include individualized interventions related to how many staff was needed to assist with bed mobility, or transfers.</p> <p>Continued review of the Comprehensive Plan of Care, dated December 2013, revealed the resident had the potential for skin breakdown due to Parkinson's Disease with a goal stating the resident would be free of skin breakdown. The interventions included turn and reposition every two (2) to three (3) hours; however, the Plan of Care was not revised with individual interventions related to how many staff was required to assist with turning and repositioning.</p> <p>Review of the SRNA Care Plan, dated 07/14, revealed the resident was to be have one (1) to</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 164</p> <p>two (2) assist of staff for transfers; was to be turned and repositioned every two (2) to three (3) hours with the assist of one (1); and was to be toileted in the bathroom with the assist of one (1) every two (2) to three (3) hours while awake and as needed.</p> <p>Interview with LPN #1, on 07/30/14 at 2:15 PM and comparison of the MDS dated 05/15/14 with the SRNA Care Plan dated July 2014, revealed the following: the MDS revealed the need for two (2) staff for bed mobility and the SRNA Care Plan revealed the resident required one (1) staff to turn and reposition the resident; the MDS revealed the need for two (2) staff for transfers, and the SRNA Care Plan revealed the resident required the assist of one (1) to two (2) for transfers; the MDS revealed the need for two (2) staff for toileting, and the SRNA Care Plan revealed one (1) staff was required for toileting. LPN #1 acknowledged there were discrepancies in the number of staff needed for ADLs comparing the MDS and the SRNA Care Plan. She also acknowledged the Comprehensive Care Plan was not revised to include specific interventions for how much assistance was needed for ADLs, for bed mobility, transfers, and toileting.</p> <p>9. Record review revealed the facility admitted Resident #36 on 03/20/14, with diagnoses which included Rhabdomyolysis, Diabetes Mellitus, Acute Renal Failure, History of Falls, Right Wrist Pain, Arthritis, and Coronary Artery Disease, and Gastroesophageal Reflux Disease. Review of Resident #36's Quarterly Minimum Data Set (MDS) Assessment, dated 06/16/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15). Further review</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 165</p> <p>revealed the facility assessed the resident as requiring extensive assist of two (2) staff for bed mobility and transfers, as requiring the assist of one (1) staff for toileting, and as frequently incontinent of bladder.</p> <p>Review of Resident #36's Comprehensive Care Plan, dated 04/09/14, revealed the resident was care planned for ADL self care deficit and at risk for complications related to the deficit. The goals stated the resident would maintain ADL self performance levels, the resident would not develop any complications related to decreased ADL self care performance, and the resident would participate with care and be clean, well groomed, and dressed. The interventions included: staff to provide assistance to meet resident's needs for ADLs, staff assist with transfers, staff assist with toileting, and staff to turn and reposition and shift weight to enhance circulation. However, the Comprehensive Care plan was not revised to include individualized interventions related to how many staff was required or how often the resident was to be turned and repositioned, or how many staff was required to assist with transfers.</p> <p>Further review of the Comprehensive Care Plan dated 04/09/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goal stated the resident would be kept clean, dry and comfortable and the resident would not develop any complications associated with incontinence. The interventions included: maintain privacy and dignity when providing perineal care after each incontinent episode. However, there was no documented evidence the Care Plan was revised with individualized interventions related to how</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 166 often or how many staff was required for incontinence care and toileting.</p> <p>Interview and review of the most recent MDS dated 06/16/14, and the SRNA Care Plan dated July 2014, with LPN #1, on 07/30/14 at 3:20 PM, revealed the MDS was coded for two (2) staff for bed mobility and the SRNA Care Plan indicated repositions self in bed; the MDS was coded for two (2) staff for transfers and the SRNA Care Plan indicated one (1) staff was needed for transfers. LPN #1 indicated there were discrepancies in the MDS and SRNA Care Plan. She further indicated the Comprehensive Care Plan was not revised with individualized interventions related to this resident's required assistance with bed mobility, transfers, incontinence care, and toileting.</p> <p>10. Medical record review revealed the facility admitted Resident #37 was admitted on 09/06/08 with diagnoses which included Dementia, Chronic Obstructive Pulmonary Disease (COPD), Depressive Disorder, Coronary Artery Disease (CAD), Congestive Heart Failures (CHF), Osteoarthritis, and Hypertension (HTN). Review of the Quarterly MDS Assessment, dated 07/01/14, revealed Resident #37 required extensive two-person physical assistance for bed mobility, toileting, and transfers. Further review revealed the resident was assessed to be unsteady, and only able to stabilize with staff assistance. In addition, the resident was assessed as being always incontinent of bowel and frequently incontinent of bladder.</p> <p>Review of the Comprehensive Care Plan, dated 06/16/14, revealed Resident #37 had an ADL</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 280	<p>Continued From page 167</p> <p>self-care deficit, with an intervention to "assist with transfers as needed", contradictory to the resident's assessed need for extensive assistance of two (2) persons. Continued review revealed the Care Plan was not revised to address the resident's unsteadiness during standing and transfers. Further intervention included turn and reposition, shifting weight to enhance circulation; however, the Care Plan was not revised to state how often or how many staff was required to turn and reposition the resident. The Comprehensive Care Plan further stated the resident had the potential for complications associated with incontinence. The interventions included maintaining privacy and dignity when providing perineal care after each incontinence episode. However, the care plan was not revised with individualized interventions related to the number of staff required or how often the resident was to be toileted and receive incontinence care.</p> <p>Review of the SRNA Care Plan dated 07/14, and the MDS Assessment dated 07/01/14 for Resident #37 with LPN #1 on 07/30/14 at 10:45 AM revealed the SRNA Care Plan indicated the resident was independent with transfers and mobility, and the MDS stated the resident required two (2) person assist for transfers and bed mobility. Further review revealed the SRNA Care Plan indicated the resident was continent of bowel and only occasionally incontinent of bladder and the MDS stated the resident was always incontinent of bowel and frequently incontinent of bladder. LPN #1 acknowledged the inconsistencies in the SRNA Care Plan and MDS and indicated the Comprehensive Care Plan was not revised with individualized interventions to designate how many staff was required to assist with transfers, bed mobility, and toileting.</p>	F 280		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 280	Continued From page 168  11. Review of Resident #11's medical record revealed the facility admitted him/her on 06/27/13, with diagnoses which included Diabetes, Senile Dementia, Delusion and Hypertension. Review of Resident #11's Quarterly MDS Assessment, dated 04/10/14, revealed the facility assessed the resident as being severely cognitively impaired.  Continued record review revealed a Nurse's Note dated 11/15/13, which stated Resident #11 had been found on the floor and had some confusion and the Physician was notified. Review of the Physician's Telephone Order dated 11/18/13, revealed an order for urine for a Urinalysis with Culture and Sensitivity to be obtained. Record review revealed the urine was obtained and sent to the laboratory (lab). Review of the lab report dated 11/21/13, revealed the results showed Escherichia Coli (E-coli) in the resident's urine. Record review revealed a Physician's Telephone Order dated 11/21/13 for Macrobid (an antibiotic) 100 milligrams (mgs) by mouth every twelve (12) hours for seven (7) days.  Review of Resident #11's Comprehensive Care Plan, dated 12/19/13, revealed the resident was care planned for bowel and bladder incontinence. However, further review of the Care Plan revealed no documented evidence Resident #11 had been care planned for the UTI or risk for further UTIs related to his/her bowel incontinence and no evidence the care plan was revised with intervention to monitor during the treat of the UTI.  Interview, on 07/02/14 at 4:38 PM, with MDS Coordinator #3, for the unit on which Resident #11 resided, revealed MDS Coordinators were	F 280		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 169</p> <p>responsible for revising and updating residents' care plans. MDS Coordinator #3 stated care plans were updated daily from what was reported about a resident in the facility's morning meeting. Continued interview with MDS Coordinator #3 revealed if a resident had a UTI, then the care plan should be revised for infections, not necessarily for UTI's and interventions added for monitoring during the infection. The MDS Coordinator indicated Resident #11 should have had his/her care plan revised for the risk for infection as he/she had a history of a UTI and was incontinent of bowel and bladder.</p> <p>Interview with the Director of Nursing (DON), on 07/03/14 at 5:20 PM, revealed Resident #11's care plan should have been revised for infections. She indicated this was important because the facility would need to monitor for signs and symptoms of further infection.</p> <p>12. Review of the medical record revealed the facility admitted Resident #24 on 05/21/14, with diagnoses which included Chronic Dizziness, Adult Failure to Thrive, and Hypertension.</p> <p>Review of the Advanced Practice Registered Nurse (APRN's) Note, dated 06/05/14, revealed Resident #24 had a low potassium level (hypokalemia) of 3.3 mille-equivalents per liter (normal range is 3.5 - 5.3 mille-equivalents per liter). The ARNP ordered potassium supplements with repeat laboratory testing, and the resident's potassium level had returned to normal on 06/09/14.</p> <p>Review of the Nurses Notes, dated 06/24/14, revealed LPN #12 noted a change in Resident #24's bilateral lower extremities when they felt</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 170</p> <p>cool to the touch on assessment. Continued review revealed the nurse notified the Physician, who ordered the application of TED hose each morning, with removal of the stockings at night. (TED hose are compression stockings worn to promote circulation, and minimize swelling, to the lower extremities).</p> <p>In addition, the Physician ordered a B-type Natriuretic Peptide (BNP) blood level. (An elevated BNP level is indicative of congestive heart failure characterized by fluid retention). The laboratory result revealed an elevated BNP of 668, with normal being a value less than one hundred (100). The Physician was notified of the results and orders were given for Lasix, 20 milligrams (mg) daily for four (4) days and a potassium blood level to be re-checked on 06/26/14. (Lasix is a diuretic, a medication prescribed to remove excess fluid from the body. A low potassium level is a side effect of Lasix administration.)</p> <p>Continued review of the Nurses Notes and laboratory results revealed over the next fourteen (14) days, Resident #24's potassium level was checked three (3) more times and potassium supplements were ordered and adjusted by the Physician in order to return the resident's potassium level to a normal range.</p> <p>Review of the Comprehensive Care Plan, dated July 2014 for Resident #24 revealed no revisions were made to reflect the resident's change in status, including two (2) episodes of hypokalemia, an elevated BNP indicative of congestive heart failure, or new orders for TED hose and medications. Continued review of the Care Plan revealed no documented evidence the Care Plan</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 280	<p>Continued From page 171</p> <p>was revised with interventions related to the application and removal of the TED hose daily, and no directives for monitoring the resident's response to the TED hose or the new medications.</p> <p>Interview with RN #4, on 07/29/14 at 11:30 AM, revealed she was the Unit Manager where Resident #24 resided. She stated there had been staffing changes among the MDS Nurses, and Care Plans were in the process of being updated. Continued interview revealed all Physician's orders, and any changes in residents' conditions, were reviewed daily Monday through Friday during the morning management meeting. She further stated, related to Resident #24, the Care Plan should have been revised to reflect the changes in his/her condition, and new interventions, including the TED hose, orders for laboratory tests and medications, and monitoring should have been added.</p> <p>Further interview with LPN #1 on 07/27/14 at 11:05 AM, and 07/30/14 at 10:45 AM and 4:30 PM revealed starting February 2014 she only did the development of Care Plans with the Admission, Annual, and Significant Change MDSs and no longer revised the Care Plans with Quarterly MDSs. information. She further stated staff would not know how to care for the resident just by checking the Comprehensive Care Plan for the residents' ADLs and would need to refer to the SRNA Care Plan for individualized interventions. Further interview revealed she was updating the SRNA Care Plans until 02/01/14, and then it was the Assistant Directors of Nursing (ADON) responsibility to ensure they were updated with any changes needed and also reviewed monthly and she indicated it would be</p>	F 280		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 172</p> <p>important for continuity of the Comprehensive Care Plan and the SRNA Care Plan. However, she stated she did not communicate changes to the ADONs when completing the Quarterly MDS Assessments.</p> <p>Interview with the RN #4/ADON on South Unit on 07/31/14 at 8:26 AM, revealed she took the SRNA Care Plans to the morning meetings along with a copy of the previous days Physician's Orders and revised the Master Copy of the SRNA Care Plan during the meeting. She stated she then went to the South Unit and updated the SRNA Care Plan in the SRNA Book at the nurse's station and on the back of the resident's door. Continued interview revealed she did not use the MDS to get information for the SRNA Care Plan, and also did not review the Comprehensive Care Plan when reviewing or updating the SRNA care plans. However, she stated, she had reviewed the Comprehensive Care Plans this week and felt they should have been revised with specific interventions related to functional status to show how many staff was required to turn and reposition, to transfer, and to provide incontinence care. RN #4/ADON, stated it was her understanding that the MDS was a picture of the resident's health and the MDS information should be used to develop/revise the Comprehensive Care Plan. Further interview revealed, she felt the Comprehensive Care Plans should be consistent with the SRNA Care Plans. RN #4/ADON stated she had never compared the MDS, the Comprehensive Care Plans and the SRNA Care Plans until this was brought up during survey.</p> <p>Interview with the Director of Nursing (DON), on 08/01/14 at 9:00 AM, revealed "the care plan</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 280	<p>Continued From page 173</p> <p>should mirror the individual". She stated it would be important to make sure the care plans were developed or revised according to MDS guidelines and as changes in the residents occurred. Further interview revealed the Comprehensive Care Plan should be individualized to meet the resident's needs and staff should be able to take care of the resident by looking at the Comprehensive Care Plan. The DON indicated the Comprehensive Care Plans interventions should be specific as to how many staff was required for transfers, toileting, ADLs, incontinence care, bed mobility and should also match the SRNA Care Plan in order for staff to provide appropriate care for the residents. She stated during survey, she realized the Comprehensive Care Plans were not revised with individualized interventions related to ADLs and did not match the SRNA Care Plans. She also stated during survey she realized the SRNA Care Plans were not revised to show how much assistance the resident currently required. The DON stated the Comprehensive Care Plan should be revised in collaboration with the MDS Coordinators, the nurses, the ADON/UC and the SRNA's. However, she stated due to turn over in staff for the MDS Coordinators and ADONs this was not always done.</p> <p>Interview with the former Administrator, on 07/31/14 at 10:14 AM, who was the Administrator for the facility from 05/15/14 until 07/11/14, revealed the facility had noted that care plans were not accurate prior to the survey and they had discussed this in the morning meetings. Further interview revealed they put together a team to look at MDSs due to an internal audit showing a concern and the ADONs were reviewing the care plans for completeness.</p>	F 280			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 280	Continued From page 174 However, she stated she did not know if the care plans were revised and individualized related to functional status because she did not review them.	F 280		
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 observation, interview, review of the facility's policy and review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, revised October 2010, it was determined the facility failed to ensure the administration of medications met professional standards of quality for one (1) of thirty-seven (37) sampled resident (Resident #8) and one (1) of five (5) residents observed during the medication pass (Unsampled Resident B).  Observation revealed Licensed Practical Nurse (LPN) #5 took medications for Unsampled Resident B into the resident's room and left the medications in the cup on his/her table. The LPN did not ensure the resident took the medications before leaving the room. In addition, interview with Resident #8 revealed he/she woke up at times, and his/her medications were in a medication cup on his/her table in the resident's room.  The findings include:  1. Review of the facility's, "Medication	F 281	F- 281  Immediate corrective action for resident found to be affected:  ♦ Resident #8 had room rounds completed on August 28, 2014 by the SCC with no medications at bedside found. Interview with resident B has been completed on August 24 by the QoLA to ensure that medications are not being left at bedside.  Identification of other residents to have the potential to be affected:  ♦ SCC made rounds on September 09, 2014 to ensure that 100% room rounds done and no medication were found at bedside	

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 281 Continued From page 175  
Administration" Policy, effective December 2010, revealed under "guideline", never leave any drug in a resident's room. Continued review revealed under "procedure" medication administration personnel would bring medication to the resident's bedside; identify the resident by name and identification bracelet or picture; read the label three (3) times before administering the medication; review the five (5) rights of medication administration; administer the medication; and remain in the room while the resident took the medication.

Review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, revised October 2010, revealed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were responsible for the administration of medication or treatment as authorized by a Physician, Physician Assistant, or Advanced Practice Registered Nurse (APRN). Review revealed components of medication administration included, but were not limited to, preparing and giving medication in the prescribed dose, route and frequency.

Review of Unsampled Resident B's medical record revealed the facility admitted the resident on 09/16/08, with diagnoses which included Muscle Weakness, Depressive Disorder, Hypertension, Gastroesophageal Reflux Disease (GERD), Constipation, Iron Deficiency Anemia, and Anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 05/04/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of a thirteen (13) out of fifteen (15), indicating no cognitive impairment. Further review of the record revealed no documented

F 281 Measure taken to assure there will not be a recurrence:

- ◆ All licensed nurses and Kentucky Medication Aids (KMAs) have been educated by the SCC on the policy and procedure related to medication administration on August 25 to September 12, 2014 as well as medication pass competencies completed by the SCC, SDC, DON, ADON, WCN, ESNS, WNS or MDSN for all licensed nurses and KMAs. The education and competencies were performed on August 25 to September 12, 2014. Any Licensed nurse or KMA not receiving the education and/or competency check off will not be allowed to work a shift until completion.
- ◆ LPN #5 was re-educated on August 27, 2014 by the SCC relative to not leaving medications at the bedside.
- ◆ Beginning September 09, 2014, five daily room rounds will be completed to assure no medications are found at bedside for 4 weeks and then monthly by SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Chaplain, Administrator or licensed nurses.
- ◆ Beginning September 09, 2014 the DON, SDC, ADON, WCN, ESNS, WNS, SCC or Consulting Pharmacist will conduct at least 2 medication pass observations monthly for 3 months to ensure medications administered in the presence of the nurse/ KMA.

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014	
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 281	<p>Continued From page 176 evidence the facility had completed an assessment for self administration of medications for Unsampld Resident B.</p> <p>Observation, on 07/02/14 at 7:40 AM, revealed LPN #5 checked the Electronic Medication Administration Record (E-MAR) and obtained medications and placed them in a medication cup. The medications included: Hydrocodone/Apap 7.5/325 milligrams (narcotic pain medication), Aspirin 81 milligrams (used for pain, inflammation, fever, and heart disease), Docusate Sodium 250 milligrams (stool softener), Lisinopril 10 milligrams (antihypertensive), Levocetirizine 5 milligrams (allergy medication), Atorvastatin 40 mg (cholesterol lowering medication), Fluoxetine 20 milligrams (antidepressant medication), Ferrous Sulfate 325 milligrams (used to treat iron deficiency), Ranitidine 150 milligrams (used to treat GERD), and Thera Multivitamin (vitamin supplement).</p> <p>Continued observation, on 07/02/14 at 7:50 AM, revealed LPN #5 took the cup of medications to Unsampld Resident B, and left the cup of medications and a cup of water on the bedside table. Observation revealed Unsampld Resident B was sitting on the bed, and the nurse reminded him/her to take the medications. Observation revealed LPN #5 then washed her hands and exited the room to sign off the medications on the E-MAR, without ensuring Unsampld Resident B took the medications and leaving the medications unattended. Further observation revealed Unsampld Resident B took the cup of medications and emptied them out on the bedside table, telling the Surveyor he/she could not swallow them all at one time.</p>	F 281	<p>Monitoring for change to assure continuing compliance:</p> <p>◆ Beginning September 11, 2014, SDC will bring all audits and observations to QA weekly x 4 and then monthly for any further recommendations and or resolutions.</p> <p>Date of compliance</p>	09-27-14

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 281	<p>Continued From page 177</p> <p>Interview with LPN #5, on 07/02/14, immediately after her exit from Unsampled Resident B's room, revealed the resident took too long to take his/her pills, and she just checked back with him/her later to ensure he/she had taken the medications. Further interview revealed there were some wandering residents in the building, but she would be in the hallway to observe if any other residents wandered into Unsampled Resident B's room.</p> <p>2. Review of Resident #8's medical record revealed the facility admitted the resident on 10/16/12, with diagnoses which included Anxiety, Depression, Chronic Obstructive Pulmonary Disease and Chronic Pain. Review of the Quarterly MDS Assessment dated 03/30/14, revealed a BIMS score of fifteen (15) out of fifteen (15) which indicated the resident was cognitively intact and interviewable.</p> <p>Interview with Resident #8, on 07/01/14 at 4:00 PM, revealed one (1) or two (2) times when he/she awakened, medications in a cup had been left on his/her bedside table. Resident #8 stated he/she had observed other residents wandering into the wrong room before and was concerned they might take his/her medication while he/she was sleeping.</p> <p>Interview with SRNA #6 on 07/02/14 at 3:20 PM, revealed she had not seen any medication on any resident's bedside table; however, Resident #8 had told her his/her medication had been left on the bedside table before.</p> <p>Interview with the RN #5/Evening Supervisor, on 07/02/14 at 3:30 PM, revealed it was her expectation for all nurses to be compliant in following the accepted standards of medication</p>	F 281		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 281	<p>Continued From page 178</p> <p>administration which were to ensure medication was administered in the presence of the nurse. She stated under no circumstances should a nurse place medication in a cup on a bedside table and leave it unattended. Continued interview revealed she felt education should be provided to the nursing staff, and any infraction referred to the Director of Nursing (DON) for further action.</p> <p>Interview with the DON on 07/02/14 at 9:20 AM and at 4:40 PM, revealed all nurses were to follow Physician's Orders and the standard for medication administration. The DON stated staff was to observe residents take their medication and medications were not to be left at the bedside. According to the DON, it would be a major problem if medications were left unattended in a resident's room and a wandering resident wandered into that room. She stated the Staff Development Nurse (SDN) checked staff off on administration of medications during orientation. The DON stated when the facility recently changed over to the E-MAR, all nurses and Certified Medication Aides (CMAs) were observed performing medication pass.</p> <p>Interview, on 07/02/14 at 10:30 AM, with the SDN revealed she observed new staff on medication pass during orientation, and randomly observed medication pass about every two (2) weeks for different staff. Continued interview revealed pharmacy had observed medication pass with the conversion to the new E-MAR system. The SDN stated she had not observed staff leaving medication at the bedside before; however, indicated it could be a problem if this were done as some residents wandered. She submitted a list of sixteen (16) residents who had been</p>	F 281			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 281	Continued From page 179 assessed to be at risk for wandering/elopement, and stated three (3) of those residents were known to wander into other residents' rooms.	F 281		
F 282 SS=G	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 interview and record review, it was determined the facility failed to ensure services provided were in accordance with each resident's Comprehensive Care Plan, or the Interim Care Plan, for six (5) of thirty-seven (37) sampled residents. (#16, #17, #26, #32 and #35).  Resident #17, who had a history of constipation, was care planned to be at risk for problems with bowel elimination due to his/her decreased mobility and Paraplegia (paralysis of the lower half of the body, including the legs), with a goal for the resident to have a regular bowel elimination pattern as evidenced by a bowel movement (BM) at least one time every three (3) days. Interventions included monitoring the resident's bowel elimination status, reporting changes in bowel status to Physician, and administering and monitoring the effectiveness of bowel medications. However, Resident #17 had a period of greater than three (3) day period, from 07/15/14 through 07/19/14, with no documented evidence of a BM, and no documented evidence of assessment and monitoring of the resident's	F 282	F 282  Immediate corrective action for resident affected:  ♦ Residents # 16, #17, #26, #32 have been reassessed on July 26 to September 04, 2014 for bowel and bladder function by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS, WNS or licensed nurse and a bowel protocol put in place. In addition the care plans for the residents were updated to reflect bowel and bladder status and interventions. Resident #35 has been discharged from the facility on July 10, 2014.  Identification of other residents identified with potential to be affected:  ♦ 100% of all residents have had a pain and bowel/bladder assessment completed by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS, WNS or licensed nurse on July 26, 2014 to September 04, 2014. Care plans were reviewed at that time and revised as needed. <i>This included resident observation of all residents and interviews with residents with BIMS of 8 and above.</i>	

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	<p>Continued From page 180</p> <p>bowel elimination status as directed by the care plan. On 07/19/14 at 10:02 PM, Resident #17 received a PRN bowel medication with no documented evidence of results and/or monitoring or assessing by nurses according to the care plan. On 07/20/14, at 10:20 AM, Resident #17 complained of abdominal pain, and began to vomit bright red blood. The Physician was notified and the resident was transported to the hospital emergency room (ER), where after assessment and diagnostic testing, the resident was diagnosed with severe fecal impaction.</p> <p>Resident #32 also had a care plan related to ensuring the resident had a bowel movement (BM) every three (3) days; however, the resident experienced three (3) periods of time, between 06/25/14 and 07/18/14, of going greater than three (3) days without a documented BM, as per the care plan goal. In addition, there was no documented evidence Resident #32 was assessed and monitored, and PRN (as needed) bowel medications were administered as directed by the care plan.</p> <p>On 05/15/14, Resident #26 became acutely ill with abdominal pain, nausea and vomiting, and a firm abdomen. The resident was sent to the Emergency Room and was diagnosed with Obstipation, a severe form of constipation usually caused by obstruction of the intestinal tract. Review of the hospital Discharge Summary, dated 05/17/14, revealed Resident #26 suffered an abdominal crisis of pain and nausea, and was found to be massively constipated, with a large volume of BM induced by the administration of enemas. Although Resident #26 returned to the facility on 05/17/14, after being diagnosed and treated for Obstipation, there was no documented</p>	F 282	<ul style="list-style-type: none"> <li>◆ All residents have a bowel protocol in place as ordered by their physicians to address signs and symptoms of constipation as of September 04, 2014.</li> </ul> <p>Measure taken to assure there will not be a recurrence:</p> <ul style="list-style-type: none"> <li>◆ In-services were completed by the SDC and SCC for all licensed nurses and related to bowel assessments, bowel protocol, bowel exception report and following residents care plan. This education was performed on August 25 to September 12, 2014. Any Licensed Nurse not receiving the education by September 12, 2014 will not work a shift until having received the education.</li> <li>◆ The Bowel exception report (<i>which indicates those residents not having a BM with the last date a BM occurred</i>) will be utilized on a daily basis beginning September 11, 2014 by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS, WNS or licensed nurse to validate that all patients <i>residents</i> have had a Bowel Movement (BM), and to implement interventions via the BM protocol as needed <i>and monitor to ensure interventions have been implemented and were effective. Each resident identified will have a note placed in the medical record in order to communicate current interventions to all licensed nurses. The WNS or substituting nurse manager as listed above shall assure this is accomplished on weekends.</i></li> </ul>		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 282	<p>Continued From page 181</p> <p>evidence the facility was monitoring for bowel movements after return from the hospital, as directed by the Comprehensive Care Plan. Review of the Bowel Elimination Record, dated 05/14, revealed there was no documentation on the Record until 05/22/14, five (5) days after the resident returned to the facility from the hospital.</p> <p>Resident #16 was care planned for the potential for constipation and had a goal to produce an adequate bowel movement at least every three (3) days. However, review of the "Elimination Report" revealed Resident #16 had a period of no documented bowel movements between the dates of 06/15/14 through 06/22/14 and 07/14/14 through 07/19/14 with no documented evidence the nurses recognized Resident #16 had not had a bowel movement for greater than three (3) days and no documented evidence of intervention as per the care plan.</p> <p>In addition, newly admitted Resident #35 was care planned for "alteration in comfort/pain", related to a diagnoses of Chronic Pain, with interventions which included the administration of pain medications as ordered. However, the resident requested his/her pain medication on 07/02/14 at 8:00 PM but did not receive the medication until 07/03/14 at 3:05 PM.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 07/27/14 at 12:42 PM, revealed the facility had no written policy related to staff following the Comprehensive Care Plan or the Interim Care Plan. However, she stated it was the expectation of the facility for staff to follow each resident's written plan of care.</p>	F 282	<ul style="list-style-type: none"> <li>◆ The DON, ADON, SDC, MDSN, WCN, ESNS, WNS, licensed nurse use the BM exception report (<i>which indicates those residents not having a BM with the last date a BM occurred</i>) at daily (M-F) clinical meeting to assure patients are not having difficulty with constipation. <i>The resident's medical record will be compared to the BM Exception report in order to assure interventions are in place per policy with residents medical records and care plans updated during the clinical meeting daily to assure compliance.</i></li> <li>◆ In-services have been completed for all licensed staff and KMAs by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS or WNS related to timeliness of medication administration and policy and procedure related to pharmacy delivery of medications. This education was provided on August 25 to September 12, 2014. Any Licensed nurse or KMA not receiving the education by September 12, 2014 will not be allowed to work a shift until having been educated.</li> <li>◆ Beginning September 09, 2014, five residents will be interviewed daily by SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Chaplain, Administrator or licensed nurses to assure residents are receiving medications timely including pain medications.</li> </ul>	
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	Continued From page 182  1. Medical record review revealed the facility admitted Resident #17 on 03/29/13 with diagnoses which included Paraplegia, Muscular Disuse Atrophy, Multiple Lymphomas (cancer of plasma cells, a type of white blood cells), Depressive Disorder and Anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #17 to have a Brief Interview for Mental Status score of fifteen (15), which indicated the resident was cognitively intact. Continued review of the MDS revealed Resident #17 was assessed as always incontinent of urine and frequently incontinent of BM, and the resident required two (2) staff for extensive assistance with toileting.  Review of Resident #17's Comprehensive Care Plan, dated 04/08/13, revealed the resident was care planned to be at risk for bowel elimination problems due to the diagnosis of Paraplegia and the resident's decreased mobility. Continued review revealed the goal was for Resident #17 to have a BM at least once every three (3) days. Further review of the care plan revealed the interventions included monitoring Resident #17's bowel elimination status, reporting any bowel status changes to the Physician, and administering and monitoring the effectiveness of bowel medications.  Review of Resident #17's July 2014 computerized "Elimination Report" revealed no documented evidence, from 07/15/14 through 07/19/14, of the resident having had a BM.  Review of the July 2014 Physicians Orders revealed Resident #17 had the stool softener, Docusate Sodium 100 milligram (mg) by mouth	F 282	<b>Monitoring changes to assure continuing compliance:</b>  ♦ Beginning September 11, 2014, the DON will report findings from all audits and resident interviews to the QA committee weekly x 4 and then monthly for any further recommendations and or resolutions.  <b>Date of compliance</b> 09/27/14		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	<p>Continued From page 183</p> <p>every other day, ordered for a diagnosis of constipation. Review of the Physicians Orders revealed Resident #17 had four (4) PRN bowel medications ordered which included two (2) different mini-enemas, Senna 8.6 mg two (2) tablets by mouth daily PRN (laxative), and Polyethylene Glycol 17 grams (gm) in 240 ml (milliliters) of fluid by mouth daily PRN (laxative).</p> <p>Review of the July 2014 Medication Administration Record (MAR) revealed no documented evidence any of the four (4) PRN bowel medications were administered from 07/15/14 until 07/19/14 at 10:02 PM. Review revealed the PRN medication, Senna 8.6 mg two (2) tablets by mouth was administered on 07/19/14 at 10:02 PM and was noted to have had a "minimal effect". Further review of the MAR revealed on 07/20/14 at 11:27 AM both the PRN Senna and the PRN MOM were administered.</p> <p>Record review revealed the Nurse's Notes dated 07/15/14 through 07/18/14 contained no documented evidence of Resident #17 experienced a BM. In addition, there was no documented evidence the resident's bowel elimination status was monitored, or any of the four (4) PRN bowel medications were administered as directed by the care plan. Continued review of the Nurses Notes, dated 07/19/14 at 9:50 PM, revealed the Physician ordered Milk of Magnesia (MOM) thirty (30) ml PRN (laxative) for constipation and the medication was administered. However, continued review revealed no documented evidence the effectiveness of the MOM was monitored as per the care plan. Review of the Nurses Notes, dated 07/20/14 at 10:20 AM, revealed Resident #17 complained of abdominal</p>	F 282			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	<p>Continued From page 184</p> <p>pain and PRN bowel medications were administered as ordered. Continued review of the 07/20/14 10:20 AM Nurses Note revealed the resident vomited bright red blood two (2) times, the Physician was notified and an order was received to send the resident to the ER. The nurse also documented she had assessed Resident #17's abdomen to have positive bowel sounds in all four (4) quadrants, and noted the resident was complaining of right upper quadrant abdominal tenderness. Furthermore, the nurse noted emergency medical services (EMS) were notified to transport Resident #17 to the ER.</p> <p>Review of the hospital ER record revealed Resident #17's arrival time at the ER on 07/20/14 was 11:24 AM. Review of the ER Physician's documentation revealed the resident had "quiet" bowel sounds and was experiencing right upper quadrant abdominal pain. Continued review revealed the ER Physician ordered diagnostic testing which included a computerized tomography (CT) scan of the pelvis and abdomen. Review of the results of the CT scan revealed Resident #17 was severely impacted. Further review of the ER record revealed Resident #17 received an enema, was manually disimpacted with "good results", and was discharged back to the facility.</p> <p>Interview with Resident #17, on 07/25/14 at 10:50 AM, revealed the resident had problems related to constipation due to his/her immobility and history of cancer. Resident #17 reported having about four (4) different medications ordered for constipation. Per interview, Resident #17 stated he/she had been constipated and had not experienced a BM the week before being sent to the ER. Resident #17 stated he/she was not</p>	F 282			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 282	<p>Continued From page 185</p> <p>"positive", but thought nurses had given him/her bowel medications before going to the ER. Further interview with Resident #17 revealed he/she had been "so sick" when sent to the ER.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #6, on 07/25/14 at 2:48 PM, SRNA #8 on 07/25/14 at 3:05 PM, SRNA #31 on 07/29/14 at 3:20 PM, and SRNAs #18 and #20 on 07/30/14 at 2:55 PM, revealed all had cared for Resident #17 prior to him/her being sent to the ER and were aware the resident had a history of constipation. According to SRNA #6, SRNA #31 and SRNA #20, Resident #17 had complained of constipation prior to going out to the hospital on 07/20/14. SRNA #6 stated Resident #17 reported to her the nurses were giving him/her "stuff" for the constipation. SRNA #31 stated Resident #17 had complained of constipation prior to being sent to the ER on 07/20/14, and he had reported Resident #17's complaints to the nurses who informed him they had "given what they could". SRNA #20 stated Resident #17 had complained of constipation prior to going to the ER, and this was reported to the nurses.</p> <p>Interview with Licensed Practical Nurse (LPN) #10 on 07/29/14 at 3:55 PM, revealed she indicated she had cared for Resident #17 in July 2014 during the timeframe before the resident was sent to the ER. LPN #10 indicated she could not recall if the resident complaints of constipation prior to going to the ER on 07/20/14, or if she had performed an abdominal assessment on the resident during the week prior to him/her going to the ER. She stated Resident #17 should never go more than three (3) days without a BM due to his/her history of constipation. Continued interview with LPN #10</p>	F 282		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	<p>Continued From page 186</p> <p>revealed she thought Resident #17's Comprehensive Care Plan was located in his/her "chart"; however, after looking through the resident's medical record, she stated she did not know where the care plan was located and would have to ask another nurse. She reported she had never seen Resident #17's Comprehensive Care Plan, and indicated she was not aware of the problems or interventions located in it.</p> <p>Interview with LPN #8, on 07/30/14 at 2:40 PM, revealed she thought she had cared for Resident #17 during the 07/15/14 through 07/20/14 timeframe. She stated she could not remember if she had performed an assessment of Resident #17's abdomen prior to him/her being sent to the ER on 07/20/14, and indicated she also could not recall if Resident #17 had complained of constipation during the week prior to being sent to the ER. She stated Resident #17 could tell staff if he/she was constipated as the resident was alert and oriented. She further stated Resident #17 had a history of constipation, and should not go longer than three (3) days without a BM. Continued interview revealed LPN #8 was not aware if Resident #17 was care planned for constipation, or if interventions were in place to prevent it.</p> <p>2. Review of the medical record revealed the facility admitted Resident #32 on 05/24/13 with diagnoses which included Stroke with Right Hemiplegia (Paralysis of one side of the body), Diabetes Mellitus, Hypothyroidism, Hemorrhoids, and Seizure Disorder. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14), which indicated the resident was cognitively intact. Continued review</p>	F 282			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 282	<p>Continued From page 187 of the MDS Assessment revealed the facility assessed Resident #32 to require extensive assistance of two (2) staff for toileting, and to be frequently incontinent of urine and always continent of bowels.</p> <p>Review of Resident #32's Comprehensive Care Plan, revised June 2014, revealed the resident was care planned for a risk for bowel elimination problems due to decreased mobility and Hypothyroidism. Review of the care plan for bowel elimination revealed a goal for the resident to have a BM as least once every three (3) days. Continued review of the care plan revealed interventions included reporting changes in bowel status to the Physician, monitoring the resident's bowel elimination status, and administering and monitoring the effectiveness of bowel medications.</p> <p>Review of the June 2014 "Elimination Report" for Resident #32, revealed three (3) periods of time with no documented evidence the resident had a BM: 06/25/14 through 07/01/14; 07/03/14 through 07/08/14; and 07/14/14 through 07/18/14.</p> <p>Review of the June 2014 Physician's Orders revealed Resident #32 had a stool softener ordered twice daily for a diagnosis of constipation. Further review revealed orders for PRN bowel medications included Bisacodyl (a stimulant laxative which works by increasing activity of the intestines to cause a bowel movement) one (1) tablet by mouth at bedtime PRN; and MOM 30 ml by mouth daily PRN.</p> <p>Review of the MAR for June 2014 and July 2014 revealed the PRN MOM was administered on 06/30/14, the sixth day of no documented BM.</p>	F 282		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	<p>Continued From page 188</p> <p>Additional review of the MAR revealed no documented evidence of further PRN bowel medications having been administered through 07/18/14.</p> <p>Review of the Nurse's Notes from 06/25/14 through 07/18/14 revealed no documented evidence an abdominal assessment was performed of Resident #32, and no documented evidence PRN bowel medications were administered as per the care plan during the three (3) episodes of no documented BM for a period greater than three (3) days.</p> <p>Interview with Resident #32, on 07/31/14 at 6:25 PM, revealed sometimes he/she would go for three (3) or four (4) days or longer with no BMs. Resident #32 stated he/she thought the nurses gave him/her "something" for his/her bowels; however, the resident was not sure what was given.</p> <p>Interview with the Advanced Practice Registered Nurse (APRN), on 07/31/14 at 9:55 PM, revealed she was one of Resident #17's primary healthcare providers. Continued interview revealed the resident had a history of constipation. She indicated the resident had several PRN bowel medications orders, and the medications should be administered if the resident did not have a BM for three (3) days.</p> <p>Interview with Licensed Practical Nurse (LPN) #10, on 07/29/14 at 3:55 PM, revealed she had cared for Resident #32 in June and July 2014. LPN #10 indicated she could not recall if the resident complained of constipation from 06/25/14 through 07/18/14, or if she had performed an abdominal assessment on the</p>	F 282			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	<p>Continued From page 189</p> <p>resident during that timeframe. She stated she had never seen Resident #32's Comprehensive Care Plans, and indicated she was not aware of the problems or interventions located on it.</p> <p>Interview with LPN #8, on 07/30/14 at 2:40 PM, revealed she thought she had cared for Resident #32 during June and July 2014. She indicated she could not remember if she had performed an assessment of Resident #32's abdomen, or if Resident #17 had complained of constipation from 06/25/14 through 07/18/14. She indicated she was not aware if Resident #32 was care planned for constipation or if there were interventions in place to prevent it.</p> <p>3. Review of the clinical record revealed the facility admitted Resident #26 on 07/23/12 with diagnoses which included Coronary Artery Disease, Cerebral Vascular Disease (CVA), Depressive Psychosis, Depression, and Constipation. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed the resident as having a BIMS score of thirteen (13) which indicated the resident was not cognitively impaired. Further review revealed the facility assessed the resident to require the extensive assist of two (2) staff for bed mobility, transfers, and toileting. In addition, the resident was assessed as frequently incontinent of bowel and bladder.</p> <p>Review of Resident #26's Comprehensive Plan of Care, revised November 2013, revealed the resident had the potential for constipation related to decreased physical function and a diagnosis of Depression and CVA. The goal stated the resident would produce adequate bowel</p>	F 282			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	<p>Continued From page 190</p> <p>movements at least every three (3) days. The interventions included: encourage direct care staff to record BMs accurately, administer medications as ordered, and routinely review BM records to determine any necessary interventions.</p> <p>Review of the Nurses Notes for 05/15/14 revealed Resident #26 became acutely ill with abdominal pain, nausea and vomiting, and a firm abdomen. The resident was sent to the ER per the Physician's order, and was diagnosed with Obstipation, a severe form of constipation usually caused by obstruction of the intestinal tract. Review of the hospital Discharge Summary, dated 05/17/14, revealed Resident #26 suffered an abdominal crisis of pain and nausea, and was found to be massively constipated, with a large volume of BM induced by the administration of enemas.</p> <p>Although Resident #26 returned to the facility on 05/17/14, after being diagnosed and treated for Obstipation, there was no documented evidence the facility was monitoring for bowel movements after return from the hospital, as directed by the Comprehensive Care Plan. Review of the Bowel Elimination Record, dated 05/14, revealed there was no documentation on the Record until 05/22/14, five (5) days after the resident returned to the facility from the hospital. However, review of the Nurses Notes, dated 05/21/14 at 1:00 AM, revealed Resident #26 had several loose stools.</p> <p>Interview with RN #4/Unit Manager (UM) for the South Unit, on 07/29/14 at 5:17 PM, revealed upon return to the facility from the hospital, the facility failed to re-enter Resident #26 into the computer system, and no documentation was completed related to the resident's bowel</p>	F 282			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 282	<p>Continued From page 191 elimination. Further interview revealed the UM was not aware anyone was monitoring daily to ensure staff was documenting each shift if a resident had a BM.</p> <p>Interview with the Director of Nursing (DON), on 07/31/14 at 8:05 PM, revealed the resident would not have shown up on the Report which was run from the computer daily to identify those residents who had no BM in seventy-two hours (72) hours if the resident had not been entered into the computer system on return from the hospital. The DON stated it would be important to closely monitor Resident #26 for bowel elimination after being treated in the hospital for Obstipation. She further stated the Comprehensive Care Plan should have been followed related to ensuring the resident had a BM every three (3) days. Continued interview revealed the nurse assigned to Resident #26's care at any given time was responsible for following the care plan.</p> <p>4. Record review revealed Resident #16 was admitted by the facility on 02/01/12 with diagnoses which included Chronic Pain Syndrome, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Depression, Rheumatoid Arthritis, Congestive Heart Failure, and Constipation.</p> <p>Review of the Comprehensive Care Plan, dated 06/20/14, revealed Resident #16 was care planned for the potential for constipation and had a goal to produce an adequate bowel movement at least every three (3) days. Interventions included: encourage direct care staff to record bowel movements accurately, administer medications if ordered, observe for signs and symptoms of discomfort, and review bowel</p>	F 282		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 282	<p>Continued From page 192</p> <p>movement records to determine any necessary interventions.</p> <p>Review of the "Elimination Report" revealed Resident #16 had a period of no documented bowel movements between the dates of 06/15/14 through 06/22/14. Review of the Nurses Notes for the same period revealed no documented evidence the nurses recognized Resident #16 had not had a bowel movement for greater than three (3) days, contrary to the care planned goal for the resident. Although nursing documentation revealed the resident had abdominal assessments conducted, there was no reference to any PRN medications being administered when there was no BM after three (3) days, and no evidence the bowel record was monitored, according to the care plan.</p> <p>Further review of Resident #16's "Elimination Report" revealed another period of no documented BM between the dates of 07/14/14 through 07/19/14. Review of the Nurses Notes for the same time period revealed no documented evidence the nursing staff recognized Resident #16 had no BM every three (3) days, as per the stated goal on the Comprehensive Care Plan. In addition, continued review of the Nurses Notes revealed no documented evidence any PRN bowel medications were administered as directed by the care plan.</p> <p>Review of the MAR for June 2014 and July 2014 revealed Resident #16 had no PRN bowel medications ordered or administered between 06/15/14 and 07/19/14. Review of the Physician Orders revealed no evidence the Physician was notified when the resident did not have a BM for</p>	F 282		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 282	<p>Continued From page 193</p> <p>more than three (3) days on either occasion, and no evidence PRN bowel medications were requested by the nurse, or ordered by the Physician.</p> <p>Interview with LPN #8, on 07/30/14 at 12:50 PM, revealed if a resident did not have a bowel movement for several days she would give the resident a PRN medication on the third day if it were prescribed, or notify the Physician if an order was required.</p> <p>Interview with the DON, on 07/31/14 at 8:05 PM, revealed if Resident #16's Comprehensive Care Plan had a goal for an adequate bowel movement every three (3) days, it was her expectation for the licensed nursing staff to follow the care plan.</p> <p>5. Medical record review revealed Resident #35 was admitted by the facility on 07/02/14 with diagnoses which included Chronic Obstructive Pulmonary Disease, Hypertension, Restless Leg Syndrome, Insomnia, Anxiety, and Chronic Pain. Continued review revealed the resident was admitted at 2:15 PM.</p> <p>Review of the Interim Care Plan, dated 07/02/14, revealed Resident #35 had the identified problem of "alteration in comfort/pain". Interventions to manage the resident's pain included the administration of medications as ordered.</p> <p>Further review of the clinical record revealed Resident #35's admission orders included Oxycodone 15 mg, one (1) tablet twice daily as needed for pain.</p> <p>Review of the Nurses Notes, dated 07/02/14 at 8:00 PM, revealed RN #6 documented Resident</p>	F 282		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 282	<p>Continued From page 194</p> <p>#35 was upset because her pain medicine was not available. The nurse documented she notified the Pharmacy and was told the medication would be delivered on the at approximately midnight or 1:00 AM. Continued review revealed the nurse informed the resident the pain medication would be given when it was received from the Pharmacy.</p> <p>Interview with RN #6, on 07/31/14 at 10:05 AM, revealed Resident #35 began asking for pain medication at approximately 8:00 PM on 07/02/14, the day of admission. She stated she contacted the Pharmacy at 8:00 PM on 07/02/14 about the resident's pain medication and was told it would be delivered on the midnight run; however, the medications did not arrive at the facility until 4:00 AM on 07/03/14. At that time, Resident #35 was asleep and the nurse did not awaken the resident to administer the medication. RN #6 further stated the resident was upset and disappointed because he/she had been assured by the hospital staff his/her pain medication would be available at the facility. Further interview revealed RN #6 did not remember if she asked the Pharmacy for a STAT delivery. Continued interview revealed RN #6 did check the emergency box when Resident #35 requested pain medication, but the Oxycodone was not stocked at the ordered dose. The nurse acknowledged she did not follow the written plan of care related to managing Resident #16's pain, and should have taken additional steps to secure the medication, including informing the Physician to seek additional orders or a change in dose for the Oxycodone.</p> <p>Review of the MAR revealed the first dose of the resident's Oxycodone was not administered until</p>	F 282		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 282	<p>Continued From page 195 07/03/14 at 3:05 PM.</p> <p>Interview with the Pharmacist, on 07/31/14 at 10:45 AM, revealed Resident #35's admission medication orders were processed by the Pharmacy on 07/02/14 at 6:00 PM, and delivered to the facility on 07/03/14 at 4:08 AM. He stated the nurses were instructed to use the emergency box at the facility when medications were needed prior to delivery from the Pharmacy. He further stated if the medications were not available in the emergency box, the nurse should contact the Pharmacy and request a STAT delivery. Continued interview revealed the Pharmacist could find no documentation to indicate the Pharmacy had been contacted for a STAT delivery for Resident #35 on 07/02/14, although all calls from facilities were logged by the Pharmacy staff when the call came in.</p> <p>Interview with the DON, on 07/31/14 at 3:30 PM, revealed Resident #35's nurse should have notified the Pharmacy for a STAT delivery of the resident's medications. She stated the nurse could take other steps to ensure the resident's care was provided according to the care plan. For example, if the resident's medication was not delivered from the Pharmacy in a timely manner, and was not available in the facility's emergency box, the nurse should call the DON for assistance, and notify the Physician for possible additional orders. Continued interview revealed the DON had the expectation for the nursing staff to follow the care plan</p> <p>Resident #35 was discharged from the facility on 07/09/14, prior to the State Agency survey. An attempt to interview Resident #35 by telephone, on 07/29/14 at 3:30 PM, was unsuccessful.</p>	F 282			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure necessary care and services were provided for residents in accordance with the comprehensive assessment and plan of care related to following the facility's unwritten bowel protocol, and ensuring the availability of prescribed medications, for six (6) of thirty-seven (37) sampled residents (#16, #17, #26, #32, #35, and #36).</p> <p>Interviews with staff revealed the facility's bowel protocol directed if a resident did not have a bowel movement (BM) within three (3) days they were placed on the computerized bowel list which was printed out each day, and were to receive follow-up assessments and PRN (as needed) bowel medications.</p> <p>Resident #17, who had a history of constipation, experienced a greater than three (3) day period with no documented evidence of a BM, from 07/15/14 through 07/19/14. A PRN bowel medication was given to the resident late in the evening of 07/19/14, at 10:02 PM, with no documented evidence of results. On 07/20/14,</p>	F 309	<p>F 309</p> <p>Immediate corrective action for resident affected:</p> <ul style="list-style-type: none"> <li>Residents # 16, 17, 26, 32, 36 have been reassessed for bowel and bladder function by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS, WNS or licensed nurse and a bowel protocol put in place. In addition the care plans for the residents were updated to reflect bowel and bladder status and interventions. Resident #35 has been discharged from the facility on July 10, 2014.</li> </ul> <p>Identification of other residents identified with potential to be affected:</p> <ul style="list-style-type: none"> <li>100% of all residents have had a pain and bowel/bladder assessment completed by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS, WNS or licensed nurse on July 26, 2014 to September 04, 2014. Care plans were reviewed at that time and revised as needed.</li> <li>All residents have a bowel protocol in place as ordered by their physicians to address signs and symptoms of constipation as of September 04, 2014.</li> </ul>		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 309 Continued From page 197  
staff administered another PRN bowel medication, and obtained an order for a liquid laxative medication due to the resident's complaints of constipation. At 10:20 AM on 07/20/14, Resident #17 complained of abdominal pain, and began to vomit bright red blood. The Physician was notified and the resident was transported to the hospital emergency room (ER), where he/she was diagnosed with severe fecal impaction.

In addition, the facility failed to provide documented evidence Residents #32, #16, and #36 had a BM every three (3) days, for periods ranging from five (5) to six (6) days. Additionally, there was no documented evidence the facility followed their protocol related to completing bowel assessments and administering bowel medications as ordered for these residents.

Also, although Resident #26 returned to the facility on 05/17/14 after being diagnosed and treated for Obstipation (severe Constipation) at the hospital, there was no documented evidence the facility was monitoring the resident for bowel movements after his/her return from the hospital. Review of the Bowel Elimination Record revealed there was no documented BM after the resident returned from the hospital until 05/22/14, five (5) days later.

In addition, Resident #35 was admitted on 07/02/14 at 2:15 PM, and requested pain medication later that evening, at 8:00 PM. However, the medication was not delivered to the facility from the Pharmacy until 4:00 AM in the morning on 07/03/14, and was not administered to Resident #35 until 3:05 PM on 07/03/14. There was no documented evidence the facility

F 309 Measure taken to assure there will not be a recurrence:

- ◆ In-services were completed by the SDC and SCC for all licensed nurses and related to bowel assessments, bowel protocol (*will include assessments and interventions provided if no BM within 2 days, 72 hours, and each day thereafter to assure patient has achieved a bowel movement. The MD will be notified for any additional interventions and or orders as needed at each assessment time frame.*), bowel exception report and following residents care plan. This education was performed on August 25 to September 12, 2014. Any Licensed Nurse not receiving the education by September 12, 2014 will not work a shift until having received the education.
- ◆ The Bowel exception report (*which indicates those residents not having a BM with the last date a BM occurred*) will be utilized on a daily basis beginning September 11, 2014 by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS, WNS or licensed nurse to validate that all patients residents have had a Bowel Movement (BM), and to implement interventions via the BM protocol as needed *and monitor to ensure interventions have been implemented and were effective. Each resident identified will have a note placed in the medical record in order to communicate current interventions to all licensed nurses. The WNS or substituting nurse manager as listed above shall assure this is accomplished on weekends.*

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 198</p> <p>assessed and monitored the resident's pain, and no evidence any additional attempts to obtain the resident's medication were made.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 07/27/14 at 12:42 PM, revealed the facility had no written policy related to bowel elimination or a bowel protocol; however, she reported the facility had an unwritten protocol which staff followed. The DON stated a computerized report was generated and printed daily from the Bowel Elimination Reports, and indicated which residents had not had a BM in the past three (3) days, or seventy-two (72) hours. Continued interview revealed the Reports were given to the two (2) Assistant Directors of Nursing (ADONs) in the clinical meeting each morning Monday through Friday, and the Weekend Supervisor obtained the Report on weekends and distributed them to the nurses on each of the facility's two (2) units. The DON stated the nurses assigned to the medication carts were to complete an abdominal assessment on each resident listed on the Report. The assessment included checking for the presence of bowel sounds, and assessing for abdominal distension or firmness. She further stated the nurse was also to assess the residents' hydration status by observing the oral cavity and mucous membranes, skin turgor (elasticity) and fluid intake. Continued interview revealed the nurse could initiate non-medical interventions such as prune juice if that normally worked for the resident, or could administer a PRN laxative or obtain an order for a PRN laxative if none was ordered. She stated the resident would keep appearing on the Report until a BM was documented on the Kiosk (computerized charting</p>	F 309	<ul style="list-style-type: none"> <li>◆ The DON, ADON, SDC, MDSN, WCN, ESNS, WNS, licensed nurse use the BM exception report <i>(which indicates those residents not having a BM with the last date a BM occurred)</i> at daily (M-F) clinical meeting to assure patients are not having difficulty with constipation. <i>The resident's medical record will be compared to the BM Exception report in order to assure interventions are in place per policy with residents medical records and care plans updated during the clinical meeting daily to assure compliance.</i></li> <li>◆ In-services have been completed for all licensed staff and KMAs by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS or WNS related to timeliness of medication administration and policy and procedure related to pharmacy delivery of medications. This education was provided on August 25 to September 12, 2014. Any Licensed nurse or KMA not receiving the education by September 12, 2014 will not be allowed to work a shift until having been educated.</li> <li>◆ Beginning September 09 26, 2014, five residents will be interviewed daily by SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Chaplain, Administrator or licensed nurses to assure residents are receiving medications timely including pain medications <i>as well as if they have constipation issues, are they being addressed.</i></li> </ul>		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3578 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 199 program), and the nurses were to continue with the abdominal and hydration assessments and continue to administer other laxatives or call the Physician as needed for additional orders. The DON stated the residents who had not had a BM in seventy-two (72) hours were discussed in the clinical meetings Monday through Friday and the ADONs were to follow up with the nurses and ensure the PRN medications were administered and the assessments were documented.</p> <p>Interview with the Registered Nurse (RN) #4/Assistant DON for the South Unit, on 07/29/14 at 5:17 PM, revealed she was given a list of residents who had not had a BM in three (3) days daily Monday through Friday during the morning clinical meeting. She stated she hung the list at the nurses' station on her unit for reference by the nurses assigned to the medication carts. She explained if a resident had no BM in three (3) days, bowel assessments were to be completed by the nurse, and the nurse was to administer a PRN laxative medication or a non-medicinal intervention such as prune juice or whatever was appropriate for the specific resident. She further stated, if there was no response (no BM) later that day, the next shift was to follow up with another laxative or enema, or call the Physician for orders. Continued interview revealed there was no follow-up monitoring related to whether the laxative was given or if it was effective. However, she stated, about a week ago she started having staff turn the list back to her so she could check to see if a laxative was given and if it was effective for residents with no BM in three (3) days. She stated the Report of residents with no BM in seventy-two (72) hours was taken each morning Monday through Friday to the clinical meeting; however, each resident</p>	F 309	<p><b>Monitoring changes to assure continuing compliance:</b></p> <ul style="list-style-type: none"> <li>Beginning September 11, 2014, the DON will report findings from all audits and resident interviews to the QA committee weekly x 4 and then monthly for any further recommendations and or resolutions.</li> </ul> <p><b>Date of compliance</b> 09/27/14</p>		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 200 was not discussed individually, only the list was distributed.</p> <p>1. Review of Resident #17's medical record revealed the facility admitted the resident on 03/29/13 with diagnoses which included Multiple Lymphomas (cancer of plasma cells, a type of white blood cells), Paraplegia Not Otherwise Specified, Muscular Disuse Atrophy, Anxiety and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #17 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated no cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #17 to always be incontinent of urine and frequently incontinent of BM, and to require extensive assistance of two (2) staff with toileting.</p> <p>Review of Resident #17's Comprehensive Care Plan, dated 04/08/13, revealed the resident was care planned for "at risk for bowel elimination problem related to decreased mobility and Paraplegia". Review of the risk for bowel elimination care plan revealed a goal for Resident #17 to have a regular bowel elimination pattern as evidenced by "soft/formed" BMs at least "once every three (3) days". Continued review of the risk for bowel elimination care plan revealed interventions included: monitoring bowel elimination status; reporting changes in bowel status to the Physician; and administering medications used for bowel elimination problems and monitoring for effectiveness and side effects of the medications.</p> <p>Review of the Physician Orders for July 2014 revealed Resident #17 was to receive Docusate</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 201</p> <p>Sodium 100 milligram (mg) by mouth every other day for a diagnosis of constipation. Continued review of the Physician Orders revealed PRN bowel medications included: "Enemeez Mini Enema" one (1) per rectal every day PRN; "Docusol Mini-Enema" one (1) per rectal daily PRN; Polyethylene Glycol 17 grams (gm) in 240 milliliters (ml) of fluid by mouth daily PRN; and "Senna Laxative" 8.6 mg, two (2) tablets by mouth daily PRN.</p> <p>Review of Resident #17's "Elimination Report" for July 2014, revealed no documented evidence the resident had a BM from 07/15/14 through 07/20/14, a total of six (6) days.</p> <p>Review of the Nurses Notes from 07/15/14 through 07/18/14, revealed four (4) days of no documented BMs. Further review revealed no documented evidence the unwritten bowel protocol had been implemented for Resident #17 in regards to performance of an abdominal assessment to include whether Resident #17 had positive bowel sounds in all four (4) quadrants, and whether he/she had abdominal distention, or whether the resident's rectal vault was checked digitally for impaction. Continued review revealed no evidence of the administration of PRN bowel medications during that timeframe, although the unwritten protocol was for an abdominal assessment to be completed if the resident had not had a BM in the last three (3) days, and PRN medications were to be administered. Continued review of the Nurses Note dated 07/19/14 at 9:50 PM, revealed an order for Milk of Magnesia (MOM) thirty (30) milliliters (ml) PRN for constipation had been received, and the MOM was administered at that time. Further review of the Nurses Notes, dated 07/20/14 at 10:20 AM,</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 202</p> <p>revealed the following: Resident #17 complained of abdominal pain and PRN bowel medications were administered as ordered; the resident was drinking warm coffee and vomited bright red blood two (2) times; and the Physician was notified and an order was received to send the resident to the ER. Further review of the Nurses Note revealed the nurse assessed Resident #17 to have positive bowel sounds in all four (4) quadrants, and complaints of tenderness in the right upper abdominal quadrant. Continued review of this Note revealed a late entry for 07/19/14 documented within it, which indicated Resident #17 had PRN bowel medications given on 07/19/14 at 9:00 AM and at 6:45 PM. Review of the late entry note revealed the resident was given a PRN enema for complaints of constipation with no results, "no stool visible". However, the nurse documented the abdominal assessment as non-tender, non-distended, with bowel sounds present times four (4) quadrants.</p> <p>Review of the July 2014 Medication Administration Record (MAR) revealed the Docusate Sodium was administered every other day as ordered; however, there was no documented evidence PRN bowel medications were administered from 07/15/14 until 07/19/14 at 10:02 PM when Senna 8.6 mg two (2) tablets by mouth was given. Continued review of the MAR revealed the Senna laxative medication was again administered on 07/20/14 at 11:27 AM, and MOM 30 ml was administered at the same time. Review of the MAR, "As Needed Administrations Report" revealed: the Senna laxative was administered on 07/19/14 at 10:02 PM, and the effectiveness noted to be "with minimal effect"; the Senna and the MOM were noted to have been administered on 07/20/14 at 11:27 AM "with</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 309	<p>Continued From page 203</p> <p>no effect". Further review of the MAR and the "As Needed Administrations Report" revealed no documented evidence PRN bowel medications were administered on 07/19/14 at 9:00 AM, or on 07/19/14 at 6:45 PM, as indicated by the nurse's late entry note for that date.</p> <p>Review of the hospital ER record revealed Resident #17 arrived at the ER at 11:24 AM on 07/20/14, and was triaged at 11:26 AM by an ER Registered Nurse, who noted the resident's complained of nausea, vomiting and abdominal pain, and reported having vomited bright red blood.</p> <p>Review of the ER Physician's History and Physical revealed the resident had right upper quadrant abdominal pain and bowel sounds were noted as "quiet". Review of the ER Physician's Orders revealed they included laboratory (lab) orders, and a computerized tomography (CT) scan of the pelvis and abdomen. Review of the Radiology Results of the CT scan revealed "fecal impaction noted severely involving the rectal vault", with the "conclusion" noted as "severe fecal impaction rectal vault". Continued review of the ER record revealed the Physician noted an enema was administered and manual "disimpaction" (removal of BM) with "good results". Further review of the ER record revealed Resident #17 was discharged back to the facility at 4:10 PM in stable condition.</p> <p>Interview with Resident #17, on 07/25/14 at 10:50 AM, revealed the resident had trouble with constipation because of his/her cancer and immobility. Resident #17 reported he/she had approximately "four (4) poop medicines" ordered. Continued interview revealed prior to being sent</p>	F 309		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 204</p> <p>to the ER on 07/20/14, Resident #17 was constipated and had not had a BM all the week before. Resident #17 believed staff had given him/her bowel medications before going to the ER; however, the resident was not "positive" of this. Resident #17 reported having been "so sick" at the time of transfer to the ER.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #6, on 07/25/14 at 2:48 PM, and SRNA #8 at 3:05 PM, revealed both had cared for Resident #17. They stated they documented residents' BMs in the "Kiosk", computer system, and if any residents had not had a documented BM in three (3) days the nurses let them know, from the list, if they had given the residents bowel medications, and to watch those residents for a BM. SRNA #6 stated Resident #17 had complained of constipation prior to going out to the hospital on 07/20/14. SRNA #6 reported Resident #17 had told her the nurses were giving him/her "stuff" for the constipation. She stated she could not recall if Resident #17 had a BM the week before; however, she indicated if the resident had a BM it should be documented in the "Kiosk".</p> <p>Interview with SRNA #31, on 07/29/14 at 3:20 PM, revealed he had cared for Resident #17 before. SRNA #31 stated the facility's process was if a resident did not have a BM in three (3) days the nurses would give the resident whatever constipation medication they had ordered. Continued interview revealed the nurses had a "bowel list", and alerted the SRNAs to which residents were on it. He stated the SRNAs "generally" cared for the same residents from day to day, so they knew how long a resident went without a BM, and the nurses monitored the</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 205</p> <p>resident. SRNA #31 reported residents' BMs were documented in the "Kiosk". Per interview, SRNA #31 stated Resident #17 "usually" just went a "few days" without a BM, and it was not "usually" a week. Further interview with SRNA #31 revealed Resident #17 had complained of constipation "a couple of times" before going to the ER on 07/20/14, and he reported this information to the nurses who told him they had "given what they could".</p> <p>Interview, on 07/30/14 at 2:55 PM, with SRNA #18 and SRNA #20, revealed they had cared for Resident #17 before, and were aware he/she had problems with constipation. SRNA #20 stated Resident #17 had complained to the SRNAs of being constipated before being sent out to the ER, and the SRNAs had told the nurses. The SRNAs stated they thought the nurse had given Resident #17 enemas, but they could not be sure.</p> <p>Interview with LPN #1, on 07/25/14 at 3:11 PM, revealed the facility did not have a written bowel protocol; however, there was a process in place whereby every Monday through Friday a list was printed from the "Kiosk" (computer) for residents who had not had a BM in seventy-two (72) hours, and the list was given to the nurses on the medication carts. LPN #1 stated when she received a list of residents without BMs, she talked to the SRNAs and verified the resident had not had a BM. She stated sometimes the SRNAs didn't get everything documented in the "Kiosk" as they should, therefore the "Kiosk" was not always accurate. Continued interview with LPN #1 revealed after verifying there had been no BMs, she performed an abdominal assessment of the resident, listening for bowel sounds and looking for distention and signs and symptoms of</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 206</p> <p>constipation. LPN #1 stated the nurses were responsible for monitoring to ensure residents had BMs. Therefore, LPN #1 stated, if a resident had not had a BM in seventy-two (72) hours, after assessment the nurse should give a PRN bowel medication; if the resident did not have PRN medications ordered they were to notify the Physician for orders.</p> <p>Interview with LPN #10, on 07/29/14 at 3:55 PM, revealed she had cared for Resident #17 before, and she indicated she thought she had cared for the resident during the 07/15/14 through 07/20/14 timeframe. She stated the facility had a bowel protocol where a "bowel care list" of residents was printed out each morning for residents who had not had a BM in seventy-two (72) hours. LPN #10 stated the list was brought to the nurses by RN #4/ADON or by the Director of Nursing (DON); and, on weekends the Weekend Supervisor obtained the list to give to the nurses. Continued interview revealed after receiving the list, the nurses asked the SRNAs about the resident's BMs, and if the resident was alert and oriented, she would ask the resident if they had a BM. She further stated the nurse assessed the resident to check for bowel sounds and distention, which would be documented in the resident's medical record. LPN #10 stated if the resident and SRNAs reported no BM, the nurse would administer PRN bowel medications. According to LPN #10, if the resident did not experience a BM before the end of the nurse's shift, who administered the PRN bowel medication, the resident's name and information was passed along to the oncoming shift and placed on the facility's twenty-four (24) hour report for follow-up. Further interview with LPN #10 revealed Resident #17 had a history of</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 309	<p>Continued From page 207</p> <p>constipation related to a diagnosis of cancer which had affected the resident's bowels. She stated Resident #17 should never go more than three (3) days without a BM due to his/her history. She indicated she could not recall if Resident #17 had complained of constipation, or if she had performed an abdominal assessment of the resident during the week prior to the resident going to the ER on 07/20/14.</p> <p>Interview with LPN #8, on 07/30/14 at 2:40 PM, revealed she had cared for Resident #17, and indicated she thought she had cared for the resident during the 07/15/14 through 07/20/14 timeframe. Continued interview with LPN #8 revealed the facility had a "bowel list" which was printed each day for residents who had no documented BM for seventy-two (72) hours. She stated RN #4/ADON gave the list to the nurses assigned to the medication carts so they could determine which of the residents they were responsible for, and check further to see if the resident really had not had a BM. LPN #8 stated if the resident had not had a BM, the nurse would perform a "bowel assessment" and administer a PRN bowel medication. She reported residents stayed on the "bowel list" until they had a BM, and if a PRN was administered with no results the Physician was notified for additional orders. LPN #8 stated she was aware of Resident #17's history of constipation, and knew she had several different PRN medications for the constipation. Further interview revealed LPN #8 could not recall if she had assessed Resident #17's abdomen during the week before he/she went to the ER, and could not recall if Resident #17 had complained of constipation before being sent out to the ER on 07/20/14. She stated Resident #17 was alert and oriented and could tell staff if</p>	F 309		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 208</p> <p>he/she was constipated. LPN #8 stated when Resident #17 went out to the ER, he/she was found to be severely impacted. The LPN indicated Resident #17 should never go greater than three (3) days without a BM related to his/her history of constipation.</p> <p>Interview on 07/31/14 at 9:55 PM, with the Advanced Practice Registered Nurse (APRN), who was Resident #17's primary healthcare provider, revealed she saw the resident at least one (1) time per month, unless the resident had an acute problem in which case the APRN saw the resident more often. The APRN stated Resident #17 had a history of constipation which the resident had discussed with her before. She explained the resident's main problem was slow peristalsis (a series of muscle contractions which occur in the digestive tract to move food through the digestive system). The APRN stated as Resident #17's peristalsis was "so slow", the resident needed "a lot" of laxatives. She further stated she had ordered several PRN bowel medications for Resident #17, and if the resident did not have a BM for three (3) days, he/she should be given a PRN bowel medication.</p> <p>Continued interview with the APRN revealed the facility had a "bowel list" of residents who had not had a BM in three (3) days, and the healthcare provider was supposed to be notified of this information. She stated if she had been notified of Resident #17 not having a BM for greater than three (3) days, she would have told the nurses to check the resident "digitally" and ask if the resident wanted a suppository. The APRN stated if the suppository didn't work, she would have had the nurses give Resident #17 an enema. Further interview revealed she did not like for any of her</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 209</p> <p>residents to go more than three (3) days without a BM, and if the resident went that long they would need "to take something" for their bowels. She stated she had never been made aware of Resident #17 having been severely impacted when he/she went to the ER on 07/20/14. She reported the primary care Physician may have known about the diagnosis of severe impaction as he had been on call that weekend.</p> <p>2. Review of the medical record revealed the facility admitted Resident #32 on 05/24/13 with diagnoses which included Stroke with Right Hemiplegia (Paralysis of one side of the body), Diabetes Mellitus, Hypothyroidism, Hemorrhoids and Seizure Disorder. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14), indicating the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #32 to be frequently incontinent of urine and always continent of bowels, and to require extensive physical assistance of two (2) staff with toileting.</p> <p>Review of Resident #32's Comprehensive Care Plan, dated 06/06/13, revealed the resident was care planned for "at risk for bowel elimination problem related to decreased mobility and Hypothyroidism". Continued review revealed a goal for Resident #32 to have a regular bowel elimination pattern as evidenced by "soft/formed" BMs at least "once every three (3) days". Continued review of the risk for bowel elimination care plan revealed interventions included: monitor bowel elimination status; report changes in bowel status to the Physician; check and remove hard stool PRN; and administer and monitor</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 210 effectiveness and side effects of medications used for bowel elimination problems.</p> <p>Further review of Resident #32's Comprehensive Care Plan, revised June 2014, revealed the resident was care planned for an ADL (activities of daily living) self care deficit related to the resident's diagnoses, including a History of Stroke with Right Hemiplegia.</p> <p>Review of the June 2014 Physicians Orders revealed Resident #32 had Docusate Sodium 100 milligram (mg) by mouth twice daily for a diagnosis of constipation. Continued review revealed orders for PRN bowel medications including Bisacodyl Enteric Coated (EC), one (1) tablet by mouth at bedtime PRN, and MOM 30 ml by mouth daily PRN.</p> <p>Review of Resident #32's "Elimination Report" for June 2014, revealed no documented evidence the resident had a BM from from 06/25/14 through 07/01/14, a total of seven (7) days, from 07/03/14 through 07/08/14, a total of six (6) days, or from 07/14/14 through 07/18/14, a total of five (5) days.</p> <p>Review of the June and July 2014 MAR revealed the scheduled Docusate Sodium was administered as ordered. However, continued review of the MAR revealed the following: for the 06/25/14 through 07/01/14 timeframe, the PRN MOM thirty (30) ml was administered on 06/30/14, the sixth day of no documented BM; and for the periods from 07/03/14 through 07/08/14, and 07/14/14 through 07/18/14, there was no documented evidence a PRN bowel medication was administered. Review of the June and July MAR, "As Needed Administrations</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 309	<p>Continued From page 211</p> <p>Report" revealed the MOM was administered on 06/30/14 at 9:47 AM, with the "effectiveness" documented as "with good effect" at 10:59 AM, even though the Elimination Report had no documented evidence of a BM on that date. Further review of the Report revealed no documented evidence a PRN bowel medication was administered from 07/03/14 through 07/21/14.</p> <p>Review of the Nurses Notes from 06/25/14 through 07/18/14 revealed no documented evidence the unwritten bowel protocol was implemented for Resident #32 related to the performance of an abdominal assessment after the resident went three (3) days without a BM, even though staff interviews revealed the unwritten protocol directed staff to complete an abdominal assessment when there was no BM in three (3) days.</p> <p>Interview with Resident #32, on 07/31/14 at 6:25 PM, revealed the resident sometimes went three (3) or four (4) days, or longer, with no BM. Continued interview revealed Resident #32 thought he/she got "something" for his/her bowels, but was not sure what it was. Further interview revealed Resident #32 had hemorrhoids which were painful at times.</p> <p>Interview with LPN #10, on 07/29/14 at 4:17 PM, revealed she had cared for Resident #32 before, and she thought she had cared for the resident between 06/25/14 and 07/18/14. She stated the facility's unwritten bowel protocol should have been followed for Resident #32. Continued interview revealed LPN #10 could not recall if Resident #32 had been on the "bowel care list", printed each morning for residents who had not</p>	F 309		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 309	<p>Continued From page 212</p> <p>had a BM in seventy-two (72) hours. Further interview revealed she could not recall if she had assessed the resident's abdomen during that timeframe. She stated the resident should not go longer than three (3) days without a BM.</p> <p>Interview with LPN #8, on 07/30/14 at 2:40 PM, revealed she had cared for Resident #32, and thought she had cared for the resident from 06/25/14 through 07/18/14. Continued interview with LPN #8 revealed she could not recall if Resident #32 was on the "bowel list" during that timeframe, and she did not remember assessing the resident's abdomen during that time.</p> <p>Interview, on 07/31/14 at 9:55 PM, with the APRN who provided healthcare services for Resident #32, revealed if the resident was on the "bowel list" of residents who had not had a BM in three (3) days, he/she would require a PRN bowel medication. The APRN stated she did not like her residents to go longer than that without a BM.</p> <p>3. Review of the medical record revealed the facility admitted Resident #26 on 07/23/12 with diagnoses which included Coronary Artery Disease, Cerebral Vascular Disease, Depressive Psychosis, Depression, and Constipation. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed the resident as having a BIMS score of thirteen (13), which indicated the resident was cognitively intact. Further review of the MDS revealed the facility assessed the resident as requiring the extensive assist of two (2) staff for bed mobility, transfers, and toileting. In addition, the facility assessed the resident as being frequently incontinent of bowel and bladder.</p>	F 309		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 213</p> <p>Review of Resident #26's Comprehensive Plan of Care, revised 11/13, revealed the resident had the potential for constipation with a goal stating the resident would produce adequate bowel movements at least every three (3) days. There were several interventions including: encourage direct care staff to record BMs accurately, administer medications as ordered, and routinely review BM records to determine any necessary interventions.</p> <p>Review of the Bowel Elimination Record, dated 05/14, revealed Resident #26 had a BM documented on 05/12/14 as large and soft; and, on 05/15/14 as medium and soft at 2:42 PM.</p> <p>Review of the Nurses Notes dated 05/15/14, revealed Resident #26 became acutely ill at 6:45 PM, when the resident exhibited nausea and vomiting. At 8:30 PM, the resident again vomited. At 11:50 PM, the resident had increased vomiting with a new onset of a firm abdomen and a decrease in bowel sounds. Continued review of the Nurses Notes revealed throughout the evening of 05/15/14, the nurse monitored the resident's condition, assessed the abdomen, was in contact with the Physician and the APRN, and administered medications based on new orders as they were received. At 11:50 PM, Resident #26 was sent to the ER per the Physician's order.</p> <p>Despite the resident's history of adequate BMs in the previous three (3) days, a review of the Hospital Discharge Summary dated 05/17/14 revealed Resident #26 was admitted with a diagnosis of Obstipation (a severe form of constipation usually caused by obstruction of the intestinal tract). Continued review revealed the resident had vomiting, an abdominal crisis of pain</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 214</p> <p>and nausea, and was found to be massively constipated. Further review revealed a large volume of stool was induced via enemas and a large amount of material was pulled via the nasogastric tube (a tube which is passed through the nose and into the stomach). Review of the report for the CT (Computerized Tomography) Scan of the Abdomen and Pelvis performed on 05/16/14 revealed the rectum was distended with stool measuring eight (8) centimeters diameter, and the stomach was distended. Further review of the Summary revealed mild Pneumonia was identified and the resident was started on Rocephin (antibiotic medication).</p> <p>Although Resident #26 returned to the facility on 05/17/14, after being diagnosed and treated for Obstipation, there was no documented evidence the facility was monitoring the resident's bowel movements after his/her return from the hospital. Review of the Bowel Elimination Record revealed there was no documentation until 05/22/14, five (5) days later after the resident returned to the facility. However, review of the Nurses Notes, dated 05/21/14 at 1:00 AM, revealed the resident had several loose stools.</p> <p>Interview with RN #4/Unit Manager (UM) for the South Unit where Resident #26 resided, on 07/29/14 at 5:17 PM, and review of the Elimination Report with the UM, revealed there was no documentation to indicate the resident did, or did not, have a BM on any shift from 05/17/14 through 05/20/14. The UM explained, since there was no documentation at all, it looked as though the resident was not put back in the system prior to 5/21/14; therefore, the SRNAs were not able to document anything related to the resident's BMs or lack thereof. The UM stated</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

(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 309	<p>Continued From page 215</p> <p>when a resident was transferred out of the building, they were taken out of the main computer system of the facility, and when the resident returned they were to be entered back into the system. She further stated the floor nurses, the DON, the MDS Coordinators and a few others, including herself, had the ability to take residents out of the system and enter them back into the system. Continued interview revealed she had no knowledge anyone was monitoring daily to ensure staff were documenting on each shift if a resident had a BM. She further stated the computer gave a percentage at the end of each shift to show how much required documentation had been completed, and indicated which questions had not been answered. The UM stated she looked at this daily Monday through Friday and reminded the SRNAs to document in the Kiosk about 2:30 PM; however, she was unsure sure if the nurses on the second and third shifts, and on the weekends, knew how to do this.</p> <p>Interview with the DON, on 07/31/14 at 8:05 PM, revealed the nurses on the unit took the residents out of the computer system when they were transferred out of the facility, and the nurse assigned to the resident upon the resident's return was to enter the resident back into the system. She stated there was no check system she was aware of to ensure residents were put back in the system when they returned to the facility. Continued interview revealed the resident would not show up on the Report which was run from the computer daily which indicated those residents not having a BM in seventy-two hours (72) hours if the resident had not been entered into the system on return from the hospital. She stated it would be important to</p>	F 309		

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 216 monitor Resident #26 closely for BMs upon return to the facility after being treated in the hospital for Obstipation.</p> <p>4. Medical record review revealed Resident #16 was admitted by the facility on 02/01/12 with diagnoses which included Anemia, Chronic Pain Syndrome, Chronic Obstructive Pulmonary Disease, Hypertension, Depression, Congestive Heart Failure, and Constipation.</p> <p>Review of Resident #16's Comprehensive Care Plan, dated June 2014, revealed he/she was care planned for the potential for constipation, and the goal was for the resident to produce an adequate bowel movement at least every three (3) days. Continued review revealed interventions to encourage direct care staff to record bowel movements accurately, give medications if ordered, observe for signs and symptoms of discomfort, and review bowel movement records to determine any necessary interventions.</p> <p>Review of the "Elimination Report" revealed no documented evidence Resident #16 had a bowel movement between 06/15/14 and 06/22/14. Continued review revealed no documented BM between the dates of 07/14/14 and 07/19/14.</p> <p>Review of the Nurses Notes and the "Daily Skilled Notes" for the same periods revealed no documentation related to Resident #16's lack of a BM for more than three (3) days. Continued review of the Notes revealed no documented evidence the Physician was notified, or the need for PRN bowel medications or other interventions were identified and addressed.</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 217</p> <p>Review of the MAR for the months of June and July 2014 revealed Resident #16 had no ordered PRN bowel medication.</p> <p>Further review of the Nurses Notes, and review of the Physician Orders, revealed no documented evidence the Physician was notified by the nurse to seek orders for PRN bowel medications after the third day with no bowel movement on either occasion.</p> <p>5. Record Review revealed Resident #36 was admitted by the facility on 03/20/14 with diagnoses which included Dehydration, Diabetes, Coronary Artery Disease, Hypertension, and Gastroesophageal Reflux Disease.</p> <p>Review of the Comprehensive Care Plan for Resident #36, dated 04/09/14, revealed the facility had not care planned the resident for constipation. Continued review revealed no interventions were in place related to monitoring the resident for adequate BMs per the facility's unwritten protocol.</p> <p>Review of Resident #36's "Elimination Report" revealed three (3) episodes of no documented bowel movement for longer than three (3) days, from 06/01/14 through 06/06/14; 06/15/14 through 06/21/14; and, 07/01/14 through 07/07/14.</p> <p>Review of the Nurses Notes and the Daily Skilled Notes for the same periods, revealed no documented evidence the nursing staff recognized Resident #36 had not had regular bowel movements.</p> <p>Review of the MAR for June 2014 and July 2014</p>	F 309			

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/01/2014
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 309	<p>Continued From page 218</p> <p>revealed Resident #36 had an order for MiraLax, seventeen (17) grams in eight (8) ounces of water, to be given by mouth daily as needed for constipation. Continued review of the MAR revealed no documented evidence the medication was given when the resident went without a bowel movement for more than three (3) days on three (3) occasions. Continued review revealed no documented evidence the Physician was notified to seek orders after the third day with no bowel movement, on any occasion, as would be indicated according to the facility's protocol for bowel management.</p> <p>Interview with LPN #8, on 07/30/14 at 12:50 PM, revealed she did not recall if Resident #36 had been on the "Bowel Exception Report" in June of 2014 or July of 2014, and she did not remember what, if any, interventions were implemented for the resident during the three (3) above-noted occasions.</p> <p>Interview with LPN #12, on 07/30/14 at 1:10 PM, revealed residents should have a bowel movement every three (3) days. Continued interview revealed that a list was generated in the facility's daily morning meeting, and a copy was given to the licensed staff to alert them of residents who had not had a bowel movement for three (3) days. He stated the licensed staff was to conduct a bowel assessment on the third day, and inform the SRNAs for assistance in monitoring the identified residents. LPN #12 reported he did not recall if Resident #36 was on the list during the month of June 2014. He further stated if Resident #36 had no bowel movement for three (3) days, he/she should have been given a bowel medication on the third day and a bowel assessment should have been completed.</p>	F 309			