

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

PRINTED: 01/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/15/2015
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELY RD. LOUISVILLE, KY 40216	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 01/14/15 and concluded on 01/15/15 to investigate KY22685 in conjunction with KY22686. The Division of Health Care unsubstantiated the allegation for KY22685 with no deficiencies cited. The Division of Health Care substantiated the allegation for KY22686 with deficiencies cited.	F 000	F 000 This plan of correction is prepared and executed because it is required by the provisions of State and Federal law and not because Summerfield Health and Rehabilitation Center agrees with the citations noted on the pages of this Statement of Deficiencies.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) and an Unsampled Resident was free of significant medication errors. On 01/03/15 Resident #1 was incorrectly administered an accu chek blood stick that was intended for Resident #2. The findings include: Review of the facility's policy titled "Medication Pass Administration", undated, revealed staff were to check the "5 Rights" for each and every medication given. The policy required staff, when pulling medications, to check the residents MAR, pull the appropriate medications, then double check the medications against the MAR.	F 333	F 333 1. Resident #1 has experienced no adverse reaction nor has she required any care plan revisions as a result of this event. 2. All residents have the potential to be affected by this same deficient practice. The Director of Nursing reviewed the past month's grievance reports, resident council minutes, and Ombudsman reports as a means of identifying other residents who may have been affected. Additionally, the Director of Nursing reviewed all medication error reports for the last 30 days to identify affected residents. This was completed on January 31, 2015. No pattern of deficient practice was found. 3. The Assistant Director of Nursing will be responsible for ensuring licensed nursing staff and CMTs have been reeducated on the facility's medication administration policy.	February 16, 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

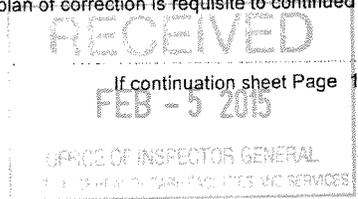
(X6) DATE

A. Newfort

X Administrator

X 2-5-15

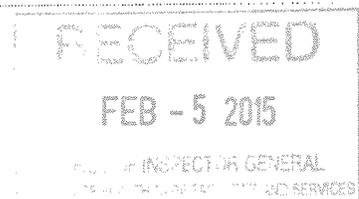
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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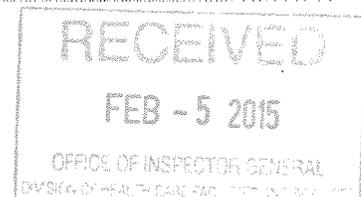
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F 333	Continued From page 1 Review of the medical record for Resident #1 revealed the facility admitted the resident on 05/25/11 with diagnoses including Chronic Kidney Disease, Cervicalgia and Atrial Fibrillation. Review of Resident #1's annual Minimum Data Set assessment dated 12/08/14 revealed the facility assessed the resident to be cognitively intact. Review of physician's orders dated 01/01/15 through 01/31/15 revealed staff was to administer an accu chek test once a week before breakfast for Resident #2. However, review of a facility investigation, dated 01/03/15, revealed that on 01/03/15 at 10:00 AM, an agency nurse administrated an accu chek by poking the right middle finger of Resident #1, instead of Resident #2. Review of a written statement by the agency nurse, dated 01/09/15, revealed the agency nurse arrived at the facility at 6:00 AM on 01/03/15 and that was her first time ever being at that facility. The agency nurse stated she did not receive report until 7:00 AM. The agency nurse stated she had twenty (20) residents that day on the 200 hall and three (3) of those twenty (20) residents had the same last name. The agency nurse stated during report she asked who had accu cheks that needed done and only the last name of the residents' were given. The agency nurse stated at that time she only knew about the couple Mr. and Mrs. of the same last name, Resident #2 and Unsampled Resident A, who share a room, and was not told about a third resident with the same last name, Resident #1. The agency nurse stated that she was not told specifically which resident of that last name was to receive the accu chek and she highlighted the	F 333	F33 (Continued from page 1) Following the training, a post test will be administered to confirm comprehension of the material. This will be completed by February 15, 2015. Review of the facility medication administration policy is part of new hire orientation for staff with med pass duties. The Assistant Director of Nursing has created an orientation packet for agency staff. This packet includes the facility policy for medication administration as well as the process for resident identification. Agency staff will sign an acknowledgement of receipt and understanding of the packet material. The DON or ADON will confirm that licensed agency staff being utilized have returned the acknowledgement. Packet distribution to agency staff will begin February 9, 2015. 4. The Director of Nursing will track and trend medication error reports and present her findings to the QA Committee so that compliance or need for additional training or system modification may be determined. The facility's consultant pharmacist will conduct med pass reviews on a quarterly basis.	



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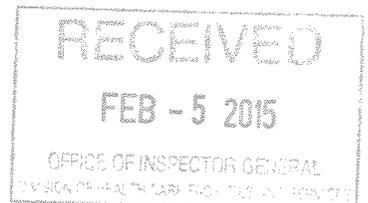
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F 333	<p>Continued From page 2</p> <p>wrong resident with that last name (Resident #1). The agency nurse stated she gathered supplies and proceeded into Resident #1's room. The agency nurse stated she introduced herself and told the resident what she was going to do before she began. The agency nurse stated on the written statement she did not poke Resident #1's finger.</p> <p>Review of the facility document titled " Elmcroft Senior Living Verbal/Coaching Form," revised October 2012, revealed the agency nurse realized she had the wrong resident, Resident #1, after poking the residents finger. The agency nurse signed and dated the form.</p> <p>Interview with the Director of Nursing (DON), on 01/15/15 at 11:00 AM, revealed she was not made aware of the incident until 01/05/15 after arriving to work that morning and discovering a incident report underneath her office door. The DON stated after reading the incident report she questioned the nurse in charge during the incident, LPN #2. The DON stated LPN #2 told her that the agency nurse did not verify she had the correct resident when administrating an accu chek. The DON further stated that before any agency staff can work at their facility the agency staff has to be trained for two (2) hours of shadowing training. The DON stated the shadowing training consists of agency staff following a facility nurse for two (2) hours and seeing how the facility is ran and how the facility performs accu cheks, medication pass, meals, skin checks and note taking.</p> <p>Interview with LPN #2, on 01/15/15 at 11:30 AM, revealed she was the charge nurse on duty for the 200 Hallway on the date of the incident. LPN</p>	F 333	<p>F 133 Continued from page 2</p> <p>The review evaluations will be present- ed to the QA Committee so that compliance or need for additional training or system modification may be determined. This will be done for the next 4 quarters.</p>	



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F 333	<p>Continued From page 3</p> <p>#2 stated the morning of 01/03/15 Resident #1's daughter approached her and stated that her family member, Resident #1, had called her upset because an agency nurse was trying to draw blood from him/her. LPN #2 stated that herself and Resident #1's daughter walked down to Resident #1's room and that is when Resident #1 stated that the agency nurse had stuck his/her finger and drew blood. LPN #2 stated she then immediately found the agency nurse and questioned her about the incident. LPN #2 stated the agency nurse told her that she stopped herself before administering an accu chek on Resident #1. LPN #2 stated that she did re-educate the agency nurse on the "5 Rights" and had the nurse sign a facility form. It was during that time the agency nurse admitted to administrating the accu chek on Resident #1. LPN #2 stated that she had never seen or worked with the agency nurse before and was not aware if the agency nurse had received the two (2) hours of shadowing training.</p> <p>Interview with Resident #1, on 01/15/15 at 2:00 PM, revealed the agency nurse administrated the accu chek on the resident's right middle finger the morning of 01/03/15. Resident #1 stated he/she was upset after the agency nurse administrated the accu chek and knew it wasn't correct. Resident #1 stated he/she never received incorrect medication or care in the past while living at this facility.</p> <p>Review of the agency nurse time sheet for 01/03/15 provided by the nursing facility revealed it was a copy of the time sheet and was torn at the top of the sheet. The agency name could not be read. The time sheet was also faded, and hard to read the "time in" time space. There was also a</p>	F 333	



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F 333	Continued From page 4 hand written note on the time sheet that the facility had written on the copy. Interview with the Human Resource Director (HRD) of the nursing agency the facility used, on 01/15/15 at 3:10 PM, revealed the agency nurse's "time in" time was 6:00 AM on 01/03/15 and the "time out" time was 2:30 PM on 01/03/15. HRD stated that their system showed that 01/03/15 at 6:00 AM was the first time the agency nurse had ever worked at that facility and the agency nurse did not receive any other day there to work or train at that facility. Interview with the DON, on 01/15/15 at 3:30 PM, revealed she was unaware the agency nurse did not receive the two (2) hours of shadowing training. The DON stated she thought the agency nurse's time sheet read 4:00 AM instead of 6:00 AM. The DON stated the facility dropped the ball with this incident and she failed to ensure the agency nurse received the mandated facility training.	F 333			

