STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185192	A. BUILDING _____ B. WING _____	C 06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ST MATTHEWS	227 BROWNS LANE LOUISVILLE, KY 40207

(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 06/03/14 and concluded on 06/05/14 to investigate KY 21769. The Division of Health Care substantiated the allegation with deficiencies cited.	F 000		
F 282 SS=D	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 observation, interview, record review, and review of the Resident Assessment Instrument (RAI 3.0), it was determined the facility failed to follow the comprehensive plan of care regarding the treatment of pain for one (1) of the four (4) sampled residents (Resident 1). The facility failed to provide Resident #1 with scheduled routine pain medication as care planned for a total of forty-eight (48) hours. The findings include: Review of the facility's RAI Manual 3.0, Chapter 4, page 4-8, revealed the facility was responsible for assessing and addressing all care issues that were relevant to individual residents, regardless of whether or not they were covered by the RAI including monitoring each resident's condition and responding with appropriate interventions. Review of the clinical record for Resident #1 revealed the facility admitted the resident on	F 282	F 282 Step 1. The corrective actions accomplished for resident found to have been affected are as follows: 5/29/14 A pain assessment was completed for Resident #1.The resident displayed no signs of pain as identified by pain assessments revealing the absence of behaviors or characteristic of pain. 5/29/14 Family and MD were notified. Resident received routine Tylenol and Lidoderm patch. 5/30/14. A new prescription was obtained and Tramadol was resumed. Immediate corrective action included staff education regarding the prescription ordering and reordering process, as related to narcotics and how to update care plans. Staff education was completed by 07/04/14. An investigation was initiated by the Unit manager regarding the delay or missed dose, 5/30/14.The resident's care plan was reviewed by the DNS. Revisions were made related to pain assessment specific to non-verbal residents on 06/09/14.. An investigation was initiated by the Unit manager regarding the delay or missed dose, 5/30/14. Step 2 No other residents were identified as being affected. All residents identified as having scheduled narcotics for the treatment of pain received a review of their administration record, pain assessments, and care plan related to pain management. It was determined that all residents with a care plan	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Allyson Skaggs, ED — TITLE: X Executive Director — (X6) DATE: X 07/14/14

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

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F 282	Continued From page 1 07/18/05 with the diagnoses of Alzheimer's, Osteoarthrosis, Dementia, and Depression. The resident was admitted to Hospice care on 01/16/14. On 01/27/14, the resident was started on Tramadol 50mg tablet twice a day for pain. The facility developed a plan of care for Pain Management and Monitoring related to the diagnoses of Osteoporosis and Osteoarthritis of the spine with Kyphosis. The facility initiated interventions to administer pain medication as ordered; evaluate characteristics and frequency of pain; evaluate what makes the pain worse and monitor for increased levels of pain; utilize the pain monitoring tool to evaluate the effectiveness of interventions; Lidoderm Patch; and incorporate the Hospice care plan. Review of the Electronic Medication Administration Record (EMAR) revealed the Tramadol was administered on 05/29/14 at 8:00 AM, 8:00 PM, and 05/30/14 at 8:00 AM. Observation of Resident #1, on 06/03/14 at 11:06 AM, 11:14 AM, and 5:14 PM revealed no sign or symptoms of pain noted. The resident occasionally moaned but made no effort to speak or answer questions. Interview with Licensed Practical Nurse (LPN) #2, on 06/04/14 at 10:12 AM, revealed she worked the morning of 05/29/14 and discovered there were no Tramadol tablets left for the morning med pass. LPN #2 revealed the night shift nurse faxed a request to the pharmacy before leaving to have the medication sent stat. The LPN revealed she got busy and realized the medication had still not arrived, so the pharmacy was called and she was told the medication would be delivered on the next run. Further Interview with the LPN, on	F 282	related to pain management that receive controlled substance(s) for pain management had received their medications for the time period from 05/29/14 through 06/29/14, except Resident #1 for the time period 05/29/14 through the 1st dose on 05/30/14. Date of completion of review of all administration records and care plans of those residents receiving narcotic pain medications were completed by the DNS/ADNS and Unit Managers 07/11/14. Progress notes are reviewed daily by Unit Managers and DNS/ADNS during week days and by weekend supervisor on Saturday and Sunday at Clinical Start up. Should Weekend Supervisor be unavailable the Unit Managers/ADNS/DNS review the past 72 hours at Monday morning clinical start-up. Step 3 Staff education was initiated by the DNS/ADNS and Unit Managers on 05/30/14 and completed by 07/04/14 regarding medication error/omission process. Alixa Pharmacy Operations Support Specialist and Implementation Nurse completed re-education with nursing staff regarding Pharmacy P&P, and medication reorder process initiated 06/12/14 and completed by 06/19/14. ADNS completed training for any nurses that were missed by 07/04/14. Unit Managers and ADNS were retrained by Alixa as train the trainer by Pharmacy Operations Support Specialist and Implementation Nurse beginning 06/12/14 and completed by 06/19/14. Revised signage related to prescription requirements and pharmacy contact information was posted in all med rooms by 07/04/14. Alixa policies were reviewed using the Alixa binder with all manuals/P&P with the Medical Director and Alixa Consultant, 6/19/14 and they verbalized understanding.. Alixa P&P have been communicated to Hosparus and the Dialysis Center completed for current residents by 07/04/14. An informational guide for physicians and	

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F 282	Continued From page 2 06/05/14 at 2:31 PM, revealed she thought she had documented some type of a pain assessment, but was unable to find where it was written. The LPN revealed the computerized nurse charting did contain a section for pain assessments, but it was not completed and she had actually forgotten that it was even in the charting system. She stated she was told in report the Tramadol had still not been delivered from pharmacy on 05/30/14. The LPN revealed she did not know Hospice was called and that they sent in a stat prescription to the pharmacy. The LPN stated she called immediately after being told the medication was not delivered and was told it would be sent stat. The LPN revealed she called the physician at 3:04 PM and was told the prescription did not have a statement on it that said it was valid only if filled by the facility's pharmacy. The LPN revealed she did not notify the physician that the resident had not received the pain medication for thirty-six (36) hours. The LPN revealed the care plan was individualized for each patient's care and instructs the nurse on how to fix a situation. The LPN stated she had never looked at the hospice care plan and did not know what was written on their plan of care. The LPN revealed nurses should follow the resident's plan of care and revealed a potential for the resident to have increased pain if not followed. Interview with RN #2, on 06/03/14 at 5:12 PM, revealed she thought pharmacy was bringing Resident #1's Tramadol. The RN revealed Resident #1's daughter came in to visit and was concerned the resident had missed a dose of the pain medication. The RN revealed she called the pharmacy at 8:06 PM to inquire as to when the medication would be delivered and was told a new prescription was required. She told the	F 282	hospitals was created by Alixa and is sent with residents on transfer to MD appointments, dialysis or transfer to the hospital initiated on 06/23/14. Staff reeducation was completed regarding utilization of pain assessment tool per DNS, ADNS/UM, by 07/04/14., Staff reeducation regarding plan of care and accessing care plans, following MD orders, revision of care plans provided by DCE/ADNS/DNS and will be completed by 07/18/14. All new nurses are instructed in how to access care plans in new hire orientation. A list of medications available in the emergency kit has been posted in each nurse medication cart binder for easy reference. The reason for the staff education regarding the process when a medication may be missed was to prevent residents from being at risk for pain due to missed medication. Resident #1's care plan stated she would receive medications as ordered. All licensed nursing staff are following care plans as all needs are put in as MD orders and have to be marked as administered by the licensed nurse on the eMar/eTar each shift. Step 4 The Unit Managers/ADNS/DNS will complete audits which include medication error reports and their correlation with medications being missed documented in the progress notes on an ongoing basis.. Unit Managers ADNS/DNS will review 15 care plans per week per unit, ie, 15 for North wing, 15 for East Wing and 15 for West wing beginning 07/14/14 This will continue Monday through Friday on an ongoing basis until all residents have been reviewed. Moving forward DNS/ADNS/Unit Manager/MDS will review the care plans of all new admits beginning admission date of 07/14/14. The ADNS/Rehab Unit manager will monitor North Wing, The LTC Unit Manager/MDS will review East and West wings. DNS will review should any of these employees be absent or will reassign to a	

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F 282	Continued From page 3 resident's daughter that the resident required a new prescription and the pharmacy had sent a request to the physician. The RN stated the resident's daughter called Hospice and informed them of her concern regarding the resident not receiving their pain medication. The RN indicated she received a call from Hospice and was told the Medical Director at Hospice had written a new script and faxed it to the pharmacy. She did notified pharmacy of the stat medication prescription being sent and was told the medication would be sent. The RN called the pharmacy at 11:00 PM, to make sure they received the stat prescription and was told by the pharmacy technician they received the prescription, but they would not send the medication until the next day. The resident was already asleep, so she did not pull the medication from the emergency supply as instructed by the pharmacy technician. The RN stated care plans were used to follow up with care and ensure resident goals were met. The RN stated she did not know if Resident #1 had a care plan addressing the resident's needs. Further interview with RN #2, on 06/05/14 at 3:07 PM revealed she was aware Resident #1's physician would not be made aware of prescription request until the morning. She did not call the Nurse Practitioner because she did not think the Nurse Practitioner could call in a prescription for Tramadol and thought the pharmacy would send the medication after receiving the stat prescription from Hospice. The RN stated she should have notified the physician that the resident had not had his/her Tramadol pain medication all day. The RN revealed a potential for the resident to have pain by not	F 282	specific individual. Care Plans will be reviewed no later than 15 days from admission. Weekend supervisor report will be reviewed every Monday in Clinical Startup by the Unit Managers and the DNS/ADNS. Care plans will be reviewed for all patients identified as having had a med error by DNS/ADNS on an ongoing basis should they arise. A total of 2 licensed nurses will be observed weekly by the DCE/UM/ADNS/DNS performing nursing care/assessments/medication administration/documentation/treatments effective 7/15/14. Results of the employees evaluation post observation will be addressed with the employee individually immediately following. Results of these audits will be reported to the QA committee by the DNS and reviewed by the QA committee weekly x 4, then biweekly x4, then monthly x3 months beginning week of 07/06/14. A QA meeting was held on 6/5/14. This event was discussed to develop a plan of action. Alixa P&P were reviewed with the Medical Director and committee members by the Alixa Pharmacy Implementation Pharmacist on 06/19/14.	F282 07/18/14

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F 282	Continued From page 4 receiving the scheduled ordered doses of the medication. Interview with the Director of Nursing Services (DNS), on 06/05/14 at 4:34 PM, revealed the nursing staff should have assessed the resident for signs and symptoms of pain. The DNS stated she was not sure of the facility's policy for assessing resident's pain with routine medications; however, since the medication was not given an assessment should have been completed. The DNS indicated she was trained by pharmacy that prescriptions required the valid only statement and assumed they would tell the nursing staff, but did not follow up to ensure it was done. The DNS stated Resident #1's physician should have been notified as soon as the first dose was missed, but did not know this was not done. The DNS further stated the care plan was used to ensure resident care was individualized to their needs. She had not been with the facility very long and had not had a chance to review the care plans. The DNS stated she had seen care plans on residents who had a change of condition and required an update of their care plan. The DNS revealed the facility had a daily clinical meeting; however, as she was not notified of the problem prior to 05/30/14, it was not discussed that morning in the meeting.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309	F309 Step 1 The corrective actions accomplished for resident found to have been affected are as follows: 5/29/14 A pain assessment was completed for Resident #1.The resident	

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F 309	Continued From page 5	F 309		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policies Pharmacy Delivery and Cut-Off Times, Controlled Substance Prescriptions, Pain Management Guidelines, pharmacy facsimiles, Medication Reorder Form, and Pharmacy Implementation Training, it was determined the facility failed to ensure one (1) of the four (4) sampled resident's pain medication was administered as ordered (Resident #1). The facility failed to notify the resident's primary physician the medication was not available for multiple scheduled doses and did not assess the resident for pain the first twenty-four (24) hours the routine pain medication was not available.

The findings include:

Review of the facility's policy regarding Controlled Substance Prescriptions, dated May 2012, revealed the elements of a controlled substance prescription included the date, full name and address of the resident, name of the medication, strength of the medication, dosage form, quantity prescribed, route of administration, dose and frequency, duration of therapy or number of refills, diagnosis for use, prescriber name, address, and DEA registration, a manual signature, and condition which delineate the need for use of a PRN (as needed) medication. If one or more refills remained they were written on a Medication Order Form or ordered by peeling the top portion from the label and placing it on the

displayed no signs of pain as identified by pain assessments revealing the absence of behaviors or characteristic of pain. Nurse failed to document assessment. A late entry was completed by the nurse on 05/29/14 at 20:50. Staff education was completed with the nurses involved related to documentation related to pain assessments by the DNS/UM the beginning 05/30/14 and completed by 06/07/14. On 5/29/14 Family and MD were notified. Resident received routine Tylenol and Lidoderm patch. 5/30/14 A new prescription was obtained and Tramadol was resumed. Immediate corrective action included staff education regarding prescription ordering and reordering process, as related to narcotics was initiated on 05/30/14. An investigation was initiated by the Unit manager regarding the delay or missed dose, 5/30/14.The resident's care plan was reviewed by the DNS on 06/09/14 and revisions were made at that time related to pain assessment tool.

Nursing and prescriber education has taken place regarding the process for ensuring MD notification related to medication being unavailable and request for new order in the interim, which may include approval to hold the medication for one dose if MD feels the patient will not suffer any harm, or prescribe an alternative, possibly from eKit. This was completed by 07/04/14.

Upon resident exit from facility for MD appointments and dialysis a document is now sent with them in order to educate the prescriber regarding requirements for writing prescriptions, including narcotics. Hospice has also been issued this document This was initiated 06/23/14.

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F 309	Continued From page 6	F 309	Step 2	

form. Refills should be completed five (5) days in advance of need. If only one refill remained the pharmacy would contact the facility to verify that the continuation of the medication was necessary and proactively seek out a new, complete prescription for future use. If a new prescription was not obtained by the pharmacy before the medication would be due again, the facility would be notified. An emergency/stat order was scheduled to be given as soon as received or within two (2) hours, whichever was sooner.

Review of the facility's Pain Management Guideline, revised 2013, revealed the purpose was to provide a guideline for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhance quality of life. Residents were evaluated for pain upon admission, change of condition and as indicated using a standardized pain scale. Documentation and observation of care and treatment reflected ongoing monitoring of pain levels and interventions (pharmacological and non pharmacological). The documentation would be reflected on the Electronic Medication Administration Record (EMAR) and progress notes.

Review of the clinical record for Resident #1 revealed the facility admitted the resident on 07/18/05 with diagnoses of Alzheimer's, Osteoarthrosis, Dementia, and Depression. The resident was admitted to Hospice care on 01/16/14 and started on Tylenol 325 mg tablet every six (6) hours. On 01/27/14, the resident was started on Tramadol 50 mg tablet twice a day. On 03/29/14, the resident was started on Lidoderm 5% patches to be placed in the morning and removed in the evening. All of these

No other residents were identified as being affected. Progress notes were reviewed for mediations not administered, by the Unit Managers/ADNS/DNS/Weekend Manager and will be reviewed during Clinical Start up. Every residents administration record and care plan related to narcotic medications currently being reviewed by the Unit Managers, DNS and ADNS to be completed by 07/11/14, as of 07/10/14 none were found to have missed a pain medication between 05/29/14 and 06/29/14 and care plans are up

to date related to pain management/assessment.

Step 3

Staff education was initiated by the DNS and Unit Managers regarding medication error/omission process. Alixa Pharmacy representative Heather completed re-education with nursing staff regarding P&P, quick reference guide and reorder process between 06/12/14 and 06/19/14. Unit Managers and ADNS were retrained by Alixa as train the trainer by Kent Harsh from Alixa. Revised signage related to prescription requirements and pharmacy contact information was posted in all med rooms. This was all completed by 07/04/14. The process for follow up for medications not received timely is to phone and refax to pharmacy with STAT written on orders. Our new system is to contact MD immediately and obtain instructions. The DNS in conjunction with the Pharmacy manager/Pharmacy consultant will work together to find the root cause should medication be unavailable and take appropriate action depending on the findings.

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F 309	Continued From page 7 medications were used to treat the resident's pain. The facility assessed the resident using the Minimum Data Set (MDS), dated 02/26/14, as having no signs of observed pain. The facility developed a plan of care for Pain Management and Monitoring related to the diagnoses of Osteoporosis and Osteoarthritis of spine with Kyphosis. The facility initiated interventions to administer pain medication as ordered; evaluate characteristics and frequency of pain; evaluate what makes the pain worse and monitor for increased levels of pain; utilize the pain monitoring tool to evaluate the effectiveness of the interventions; Lidoderm Patch; and incorporate the Hospice care plan. Observation of Resident #1, on 06/03/14 at 11:06 AM, 11:14 AM, and 5:14 PM revealed no sign or symptoms of pain noted. The resident occasionally moaned, but made no effort to speak or answer questions. Review of the EMAR for Resident #1, dated May 2014, revealed the tramadol scheduled, on 05/29/14 at 8:00 AM and 8:00 PM and 05/30/14 at 8:00 AM, were not administered. Review of the nursing notes, dated 05/29/14 at 1:48 PM, revealed pharmacy was notified to send the missing medication stat. Interview with Licensed Practical Nurse (LPN) #2, on 06/04/14 at 10:12 AM, revealed she worked the morning of 05/29/14. During shift change narcotic count, around 7:00 AM, she noticed there were no tramadol tablets left to administer with the morning med pass. LPN #2 revealed the night shift nurse faxed a request to the pharmacy before leaving to get the medication stat. The LPN revealed she got busy and towards the end	F 309	Alixa policies were reviewed with the Medical Director and Alixa Consultant, 6/19/14. Policies were approved by the Medical Director, ED, DNS, and Pharmacy Consultant, 6/19/14. Alixa P&P have been communicated to Hosparus and the Dialysis Center. An informational guide for physicians and hospitals was created by Alixa and is sent with residents on transfer to MD appointments, dialysis, or transfer to the hospital. Staff reeducation was completed regarding pain assessment tool, and documentation by 07/04/14. A list of medications available in the emergency kit has been posted on each nurse medication cart for easy reference. A quick reference guide for ordering and refilling of medications (narcotic and non-narcotic) was created by Alixa and the DNS, 6/12/14. This guide is posted in the Alixa facility resource binder on each Nursing Unit and the DNS office. Step 4 The Unit Managers/ADNS/DNS will complete audits. The audits include medication error reports, care plans and progress notes, effective 7/10/14. This will continue Monday through Friday on an ongoing basis. Weekend supervisor report will be reviewed every Monday in Clinical Startup by the Unit Managers and the DNS/ADNS. Care plan will be reviewed for all patients identified as having had a med error by DNS/ADNS ongoing. Unit Managers ADNS/DNS will review 15 care plans per week per unit, ie, 15 for North wing, 15 for East Wing and 15 for West wing beginning 07/14/14 This will continue Monday through Friday on an ongoing basis until all residents have been reviewed. Moving forward DNS/ADNS/Unit Manager/MDS will review the care plans of all new admits beginning admission date of 07/14/14. The	

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F 309	Continued From page 8	F 309	ADNS/Rehab Unit manager will monitor North Wing, The LTC Unit Manager/MDS will review East and West wings. DNS will review should any of these employees be absent or will reassign to a specific individual. Care Plans will be reviewed no later than 15 days from admission. The weekend supervisor report will be reviewed every Monday in Clinical Startup by the Unit Managers and the DNS/ADNS. Results of these audits will be reviewed by the QA committee weekly x 4, then biweekly x4, then monthly x3 months. A QA meeting was held on 6/5/14. This event was discussed to develop a plan of action. 6/19/14 Alixa P&P were reviewed with the Medical Director and committee members by the Alixa Pharmacy Implementation Pharmacist.	F309 07/18/14

of the shift realized the medication had still not arrived, so the pharmacy was called and the LPN stated she was told it was coming on the next pharmacy run and passed the information on in report. Further Interview with the LPN, on 06/05/14 at 2:31 PM, revealed Resident #1 was assessed for pain symptoms when the 12:00 PM dose of Tylenol was given on 05/29/14. However, the LPN revealed it was not an official assessment as it was not prompted by the EMAR system. The LPN revealed the pain assessment was prompted automatically with as needed (PRN) doses, but not routine. After further discussion, the LPN revealed the computerized nurse charting did contain a section for pain assessments but it was not completed and had actually forgotten that it was even in the charting system. The LPN revealed she did not notify the physician of the missing dose of pain medication because she was in the mindset that it would arrive from pharmacy.

Interview with Registered Nurse (RN) #1, on 06/03/14 at 4:00 PM, revealed he worked on 05/28/14 and noticed the Tramadol was running low; however, the refill sticker had already been pulled for reorder several days prior so the pharmacy was not called. The RN revealed he did not call the pharmacy, but in hindsight he should have to try and find out why it had not been sent.

Further review of Resident #1's EMAR revealed the 8:00 PM dose of Tramadol was not given on 05/29/14 either.

Interview with RN #2, on 06/03/14 at 5:12 PM, revealed she was told by LPN #2 the Tramadol had not arrived from pharmacy; however, they

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were to send the medication STAT. The RN stated Resident #1's daughter came in to visit and was concerned the resident had missed a dose of the pain medication. The RN called pharmacy at 8:06 PM and was told a new prescription was required to fill the medication, but they would send a request to the resident's physician. The resident's daughter was informed that a new prescription was required and the pharmacy had sent a request to the physician. The RN stated the resident's daughter called Hospice and notified them of the situation. The RN received a call from Hospice and was told the Medical Director at Hospice had written a new script and faxed it to the pharmacy. The RN indicated she notified pharmacy of the stat medication prescription being sent and was told it would be sent. The RN stated by 12:30 AM, the medication had still not arrived and called pharmacy again. She was told by the pharmacy technician that they did receive the prescription, but would not send until the next day and to pull the medication from the emergency pharmacy box. The RN stated the resident was already asleep so she did not pull the medication from the emergency supply.

Further interview with RN #2, on 06/05/14 at 3:07 PM, revealed she was aware Resident #1's physician would not be made aware of the prescription request until the morning. The RN stated she did not call the Nurse Practitioner because she did not think the Nurse Practitioner could call in a prescription for Tramadol and thought the pharmacy would send the medication after receiving the stat prescription from Hospice. The RN revealed she should have notified the physician that the resident had not had his/her Tramadol pain medication all day. The RN

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revealed the resident likely to have potential pain by not receiving the scheduled ordered doses of the medication.

Review of Resident #1's clinical record revealed there was not a pain assessment for evening shift of 05/29/14. Review of the EMAR revealed the Tramadol was not given on 05/30/14 at 8:00 AM.

Interview with LPN #2, on 06/05/14 at 2:31 PM, revealed she was told in report the Tramadol had still not been delivered from pharmacy. The LPN revealed she did not know Hospice was called and that they sent in a stat prescription. The LPN revealed she called immediately after being told the medication was not delivered and was told it would be sent stat. The LPN revealed by 10:30 AM the medication still had not arrived and she again called pharmacy and was told they needed a prescription and had already faxed the physician. The LPN revealed she also sent a prescription request to the resident's physician. The LPN revealed she called the physician and was told the prescription did not have a statement on it that said it was valid only if filled by the facility's pharmacy. The LPN revealed she did not notify the physician the resident had not received the pain medication for thirty-six (36) hours. The LPN revealed a potential for the resident to have had increased pain.

Interview with Hospice Clinical Manager, on 06/05/14 at 2:10 PM, revealed none of the Hospice staff were aware the facility's pharmacy requirement of a statement that the prescription was only valid if filled by them. The Hospice Clinical Manager revealed no one from the facility had provided that information so the Hospice staff could be trained. The Hospice Clinical Manager

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revealed the pharmacy did send a return fax that the statement was required; however, it was sent to the long term care billing department fax which did not print paper and directed the information into the financial department's email. The Hospice Clinical Manager revealed the only reason she knew of the problem was because someone from billing had forwarded the email to her three (3) days later.

Interview with the Unit Manager, on 06/05/14 at 5:15 PM, revealed she became aware of the required statement on the pharmacy prescriptions during an orientation with the pharmacy in preparation for the transition. However, the Unit Manager revealed she did not know the nurses were not aware and had assumed the pharmacy had provided that information. The Unit Manager revealed she did not become aware the resident had not received the medication until 05/30/14 when informed by LPN #2.

Interview with the Director of Nursing Services (DNS), on 06/05/14 at 4:34 PM, revealed the nursing staff should have assessed the resident for signs and symptoms of pain. The DNS stated she was not sure of the facility's policy for assessing resident's pain with routine medications; however, since the medication was not given an assessment should have been completed. The DNS indicated she was not told there was a problem obtaining the medication until 05/30/14. The DNS was trained by pharmacy that prescriptions required the valid only statement and assumed they would tell the nursing staff, but did not follow up to ensure it was done. In addition, the DNS revealed the pharmacy had posted signs in the medication rooms, but it did not say the statement was

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required. The DNS revealed she did not check the postings for accuracy until after the State Survey Agency began their investigation regarding training. The DNS revealed she was not going to change the posting in the medication room with the correct information because that was pharmacy's job and they should be responsible to do so. The DNS revealed Resident #1's physician should have been notified as soon as the first dose was missed, but she did not know notification was not made.

Interview with the Executive Director, on 06/05/14 at 5:40 PM, revealed she was notified of the statement requirement on prescriptions during the recent transition to the new pharmacy. The ED revealed she did not ensure the facility's Medical Director, and other providers were notified of the statement requirement.

F 425 SS=E — 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation

F 425

F425

Step 1

Step 1.

The corrective actions accomplished for resident found to have been affected are as follows: On 5/29/14 a pain assessment was completed for Resident #1.The resident displayed no signs of pain as identified by pain assessments revealing the absence of behaviors or characteristic of pain. 5/29/14 Family and MD were notified. Resident received routine Tylenol and Lidoderm patch. 5/30/14 A new prescription was obtained and Tramadol was resumed on 05/30/14. Immediate corrective action included staff education regarding prescription ordering and reordering process, as related to narcotics began on 05/30/14 and was completed by

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on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy Controlled Substance Prescriptions, Pharmacy Delivery Schedule and Cut-Off Times, it was determined the facility failed to have a pharmacy system in place to ensure a prescribed medication was provided for one (1) of four (4) residents (Resident #1). The facility's pharmacy failed to train the nursing staff that prescriptions required a statement, valid only if faxed to their pharmacy. The facility pharmacy failed to post the appropriate signs with prescription requirements, and the facility failed to train the providers, including Hospice, of the statement requirements on prescriptions.

The findings include:

Review of the facility's policy Controlled Substance Prescriptions, dated May 2012, revealed the elements of a controlled substance prescription included the date, full name and address of the resident, name of the medication, strength of the medication, dosage form, quantity prescribed, route of administration, dose and frequency, duration of therapy or number of refills, diagnosis for use, prescriber name, address, and DEA registration, a manual signature, and condition which delineates the need for use of a PRN (as needed) medication. If one or more refills remained they were written on

07/04/14. An investigation was initiated by the Unit manager regarding the delay or missed dose, 5/30/14. Reeducation regarding reordering process and pain assessment documentation was performed with the nurses involved that day. The resident's care plan was reviewed by the DNS on 06/09/14 and a revision was made related to appropriate pain assessment tool at that time.

Step 2

No other residents were identified as being affected. Progress notes were reviewed for mediations not administered, by the Unit Managers/ADNS/DNS/Weekend Manager and will be reviewed during Clinical Start up on an ongoing basis.

Step 3

Nursing staff were re-educated regarding the statement "valid only if faxed to AlixaRx" which was 100% completed by 07/04/14 and initiated on 06/12/14 by the Pharmacy Operations Support Specialist, Implementation nurse and ADNS. Medication room postings have all been updated to include the "valid only" statement for controlled substances and posting were completed by 07/04/14 by the Alixa Pharmacy Consultant.

Between 05/30/14 and 07/04/14 the nursing staff were educated to notify prescriber immediately should a medication not be available. This training was completed by the UM's/DNS/ADNS and all verbalized understanding. If the medication has been prescribed by someone other than the Medical Director and that physician is unavailable, the

Medical Director will be notified and he has agreed to help obtain any needed medication. This process was reviewed with the Medical

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F 425	Continued From page 14 a Medication Order Form or ordered by peeling the top portion from the label and placing it on the form. Refills should be completed five (5) days in advance of need. If only one refill remained the pharmacy would contact the facility to verify if the continuation of the medication was necessary and proactively seek out a new, complete prescription for future use. If a new prescription was not obtained by the pharmacy before the medication would be due again, the facility was notified. An emergency/stat order was scheduled to be given as soon as received or within two (2) hours, whichever was sooner. Review of the facility's policy Pharmacy Delivery Schedule and Cut-Off Times, revised 01/16/14, revealed medications should be reordered by removing the label sticker and faxing to pharmacy four (4) days before the depletion of the medication. Medication reorders received on Friday would be available on Monday. Review of the facility's policy regarding Pharmacy Delivery Schedule and Cut-Off Times, revised 01/16/14, revealed orders faxed after the cut-off time would not be processed until the next scheduled delivery. The Facility must call the pharmacy with any exceptions, stats, new admissions. Cut off time is 12:00 PM for the 2:00 PM run and 6:30 PM for the 9:00 PM run on Monday through Friday. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 07/18/05 with diagnoses of Alzheimer's, Osteoarthrosis, Dementia, and Depression. The resident was admitted to Hospice care on 01/16/14 and started on Tylenol 325 mg tablet every six (6) hours. On 01/27/14, the resident	F 425	Director by the DNS and approved for use on June 19, 2014. Staff education was initiated by the DNS/ADNS and Unit Managers on 06/07/14 regarding medication error/omission process and completed by 07/04/14. Alixa Pharmacy Operations Support Specialist, Implementation Nurse, followed by ADNS completed re-education with nursing staff regarding P&P, and reorder process. Training was completed by 07/04/14. Unit Managers and ADNS were retrained by Alixa Implementation Nurse as train the trainer between 06/12/14 and 06/19/14. Revised signage related to prescription requirements and pharmacy contact information was posted in all med rooms no later than 07/04/14. Alixa policies were reviewed with the Medical Director and Alixa Consultant on 6/19/14. Policies were approved by the Medical Director, ED, DNS, and Pharmacy Consultant 6/19/14. Alixa P&P have been communicated to Hosparus and the Dialysis Center beginning 06/23/14 and completed by 07/04/14 by ED/DNS. This document was created by the AlixaRX Pharmacy Manager and is sent with all residents going to MD appointments, dialysis, or transfer to the hospital beginning 06/23/14. Nursing reeducation was completed regarding medications available in the emergency kit and a list has been posted in each nurse medication cart binder for easy reference per DNS/ADNS/UM's on 06/23/14. A quick reference guide for ordering and refilling of medications (narcotic and non-narcotic) was created by Alixa and the DNS, 6/12/14. This guide is posted in the Alixa facility resource binder on each Nursing Unit and the DNS office on 06/12/14. Nursing staff were educated on the informational guide between 06/12/14 and 06/19/14 by the Pharmacy Operations Support Specialist and the Implementation Nurse. All further training un the quick reference guide is done during new hire orientation for nurses.	

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F 425	Continued From page 15 was started on Tramadol 50 mg tablet twice a day. On 03/29/14, the resident was started on Lidoderm 5% patches to be placed in the morning and removed in the evening. All of these medications were used to treat the resident's pain. Review of the Electronic Medication Administration Record (EMAR) revealed the resident's scheduled Tramadol was not administered on 05/29/14 at 8:00 AM, 8:00 PM, and 05/30/14 at 8:00 AM. Interview with Pharmacy Technician #2, on 06/03/14 at 4:42 PM, revealed the facility transitioned into their pharmacy services on 05/12/14. In preparation for transition, all medications were checked and entered into the pharmacy system. The Pharmacy technician revealed Tramadol was a scheduled IV (4) medication in the state of Kentucky, so upon entering the medication into the system a prescription request should have been generated and sent to the resident's physician. The Pharmacy Technician revealed this was not done, and the first request she could find in their system was sent on 05/29/14. Interview with Registered Nurse #1, on 06/03/14 at 4:00 PM, revealed he worked on 05/28/14 and noticed they were low on Tramadol. However, the refill label had already been pulled from the package and faxed to pharmacy so he did not call the pharmacy to enquire about the medication. Review of the Medication Reorder Form, dated 05/23/14, revealed a reorder request was sent to pharmacy for the resident's Tramadol.	F 425	Step 4 A QA meeting was held on 6/5/14. This event was discussed to develop a plan of action. 6/19/14 Alixa P&P were reviewed with the Medical Director and committee members by the Alixa Pharmacy Implementation Pharmacist. The DNS/ED will communicate with the Alixa Pharmacy Consultant on a weekly basis to discuss concerns that may arise, beginning week of 06/29/14. Issues identified and results of weekly meetings will be reviewed by the QA committee weekly x 4, then biweekly x4, then monthly x3 months.	F425 07/18/14

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Interview with Licensed Practical Nurse (LPN) #1, on 06/04/14 at 10:12 AM, revealed she called and notified pharmacy at the beginning of her morning shift on 05/29/14 that the Tramadol was not available to be administered. The LPN revealed she was told it would be sent over, and when it did not arrive by 1:00 PM, she called again and asked them to send the medication over stat.

Interview with Registered Nurse (RN) #1, on 06/03/14 at 5:12 PM revealed she worked the evening of 05/29/14. The RN revealed she was told the medicine would be arriving, but it did not arrive in time for evening dose. Resident #1's daughter arrived that night and was upset the resident did not get the medicine. The RN stated she called the pharmacy again and was told a new prescription was needed in order to fill the prescription. The resident's daughter called Hospice who had their Medical Director write a stat prescription and faxed it to pharmacy. Continued interview, on 06/05/14 at 3:07 PM, revealed the RN called the pharmacy to inform them of the stat prescription being faxed and the pharmacy confirmed they did receive the prescription. However, the medication still did not arrive and with the next call the pharmacy informed the nurse the medication would be sent the next day and to pull the medication from the emergency medication box.

Review of the emergency medication box contents, not dated, revealed Tramadol was not a medication stocked in the box.

Interview with the Pharmacy General Manager, on 06/04/14 at 5:30 PM, revealed the pharmacy technicians at night have the ability to find out what is stocked in the facility ' s emergency box,

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and did not know why the facility was told to pull it from the emergency stock.

Review of the EMAR revealed the Toradol dose scheduled for 05/30/14 at 8:00 AM was also not administered.

Interview with LPN #2, on 06/05/14 at 2:31 PM, revealed she called the pharmacy again on 05/30/14 after discovering the medication had still not arrived. The LPN revealed the medication had still not arrived by 10:30 AM, so again the pharmacy was called and told the LPN a prescription would be required to provide the medication. The LPN called Resident #1 ' s physician at 3:04 PM as follow up to ensure a prescription had been sent and was notified by the Doctors office staff that the prescriptions must contain a statement that the prescriptions are only valid if filled by that pharmacy. The LPN stated she had never been told of the required statement and did not know Hospice had sent a new stat prescription the night before.

Interview with RN #2, on 06/05/14 at 3:07 PM, revealed she was never told the statement was required on a prescription

Review of the Pharmacy policy manual, dated 05/2012, revealed there was no policy that a statement reading valid only if faxed to their pharmacy was needed.

Observation of the Medication Rooms revealed pharmacy postings were hanging on the cabinets listing requirements for valid prescriptions. There was nothing on the posting regarding a statement valid only if faxed to this pharmacy.

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Interview with Hospice Clinical Manager, on 06/05/14 at 2:10 PM, revealed the Hospice staff were not aware the facility's pharmacy required a statement that the prescription was only valid if filled by them. The Hospice Clinical Manager revealed no one from the facility had provided that information so the Hospice staff could be trained. The Hospice Clinical Manager revealed the pharmacy did send a return fax that the statement was required; however, it was sent to the long term care billing department fax which did not print paper and directed the information into the financial department's e-mail. The Hospice Clinical Manager revealed the only reason she knew of the problem was because someone from billing had forwarded the e-mail to her three (3) days later.

Interview with the Pharmacy General Manager, on 06/04/14 at 5:30 PM, revealed the pharmacy start date of service was 05/16/14 so orders were processed starting at the beginning of the month. The General Manager revealed Tramadol was not a scheduled IV (4) drug in Indiana, which was where they were located, and a prescription request was not generated during the initial med drop into their system. In addition, the postings the pharmacy team hung in the med room was outdated and did not contain the correct information. The General Manager revealed the statement requirement was in their policy; however, he was unable to say where it was located. The General Manager then revealed the statement on prescriptions was generated from a recommendation from the Indiana Board of Pharmacy. The General Manager did confirm he was aware the facility was located in Kentucky. The General Manager revealed their pharmacy closed at 9:00 PM and all request go to a backup

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185192	A. BUILDING _____ B. WING _____	C 06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ST MATTHEWS	227 BROWNS LANE LOUISVILLE, KY 40207

(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
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pharmacy. The General Manager revealed if a prescription came through in the evening with the valid only if filled by their pharmacy and a new script would have to be written, or a verbal transfer of medications would need to be done. The General Manager revealed he did not know why the prescription was not filled by the backup pharmacy, as the Hospice prescription did not have the pharmacy statement on the prescription.

Further interview with the Pharmacy General Manager, on 06/05/14 at 10:02 AM, revealed Resident #1's initial medication review was completed on 04/28/14 and the pharmacy failed to notify the resident's physician a prescription would be needed to refill the medication. The General Manager revealed the pharmacy did receive the refill request sent by the facility on 05/23/14. The request was processed on 05/25/14; however, the pharmacy revealed they spoke with RN #3 on 05/25/14 and informed them the resident would be going on a leave of absence.

Interview with the RN #3, on 06/05/14 at 3:00 PM, revealed pharmacy did not call, she called them because the resident was going on a leave of absence with family and the pharmacy had not sent medication to accompany the resident. The RN stated she was told to just send the medications in the cart. The RN revealed she never told the pharmacy to not send the resident's medication, and the resident was allowed a certain number of leaves per year.

Continued interview with the Pharmacy General Manager, on 06/05/14 at 10:02 AM, revealed the pharmacy received a fax from the facility stating Resident #1 was a new admission and no

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prescriptions were sent.

Review of the fax the pharmacy received from the facility saying Resident #1 was a new admission was actually a medical record face sheet containing the resident's biographical information, payer source, provider, and next of kin.

Continued interview with the Pharmacy General Manager, on 06/05/14 at 10:02 AM, revealed Resident #1's physician was called and a message was left that a new prescription was required.

Interview with Resident #1's physician's Office Manager, on 06/04/14 at 3:25 PM, revealed the office was not notified that a prescription was needed for the Tramadol until 05/29/14 at 11:15 AM. The Office Manager revealed the Physician was not in the office on Thursdays, therefore the request was not addressed until 05/30/14. The Office Manager revealed the request did not contain any information that this was needed stat or that the resident had no medication left. The Office Manager revealed if this had been on the request form, they could have had one of the other physicians write the prescription.

Continued interview with the Pharmacy General Manager, on 06/05/14 at 10:02 Am, revealed the pharmacy received the stat prescription for Tramadol on 05/29/14 at 8:10 PM; however, cut off times to address prescriptions was 6:30 PM. The General Manager revealed the facility would need to call the pharmacy and let them know a stat order was sent in order for it to be processed and he did not know the facility nursing staff had called the pharmacy regarding the stat prescription. The General Manager revealed the

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statement about the prescription being valid only if filled by their pharmacy was put into place because prescriptions have to meet both state and federal laws. However, the General Manager revealed the statement was not a state or federal law for either Indiana or Kentucky. The General Manager revealed they were not aware the pharmacy had sent the request to Hospice to add the statement to their script to the wrong number. The General Manager revealed the pharmacy team accidentally hung the wrong postings in the facility's med room, but said the correct information was actually included in the training that was provided to the nursing staff.

Review of the pharmacy training material, effective 05/14/12, revealed no evidence anything was mentioned or written regarding the necessity of the valid if only statement on prescriptions.

Interview with the facility's Medical Director, on 06/05/14 at 3:30 PM, revealed he was not informed prescriptions required the valid if only statement and only learned of it when the pharmacy refused to fill one of his prescriptions. In addition the Medical Director revealed Tramadol was a scheduled IV (4) medication, and he had never know a schedule III (3) or schedule IV (4) drug to require an actual prescription, because those medications can just be called into the pharmacy.

Interview with the Executive Director, on 06/05/14 at 5:40 PM, revealed she did not ensure all staff and providers were notified of the required statement on prescriptions to ensure a smooth transition with the new pharmacy.

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